



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Illinois**

**Application for 2010
Annual Report for 2008**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Department's assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Services Block Grant are on file at the Office of Family Health's headquarters in Springfield. Copies may be obtained by writing or calling the office:

Ralph M. Schubert, M.Sc., M.A.
Acting Associate Director for Family Health
Division of Community Health and Prevention
Illinois Department of Human Services
535 West Jefferson Street
Springfield, IL 62702-2736

/2008/ The Department's assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Block Grant are on file at the Division of Community Health and Prevention's headquarters in Springfield. Copies may be obtained by writing or calling the Project Director at:

Myrtis Sullivan, M.D., M.P.H.
Associate Director for Family Health
Illinois Department of Human and Prevention
1112 S. Wabash St.
Chicago, IL 60605
(312) 814-2434 //2008//

/2009/The Department's assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Services Block Grant are on file at the Division of Community Health and Prevention's headquarters in Springfield. Copies may be obtained by writing or calling the office:

Myrtis Sullivan, M.D., M.P.H.
Associate Director for Reproductive and Early Childhood Services
Illinois Department of Human Services
Division of Community Health and Prevention
1112 S. Wabash St.
Chicago, IL 60605
(312) 814-2434 //2009//

An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The MCH Services Block Grant application was made available for public review/comment via posting on the Internet at www.dhs.state.il.us between June 7 and June 30, 2006. A draft was distributed to chairpersons of the following advisory committees or a senior member of the following organizations: the Illinois maternal and Child Health Coalition; the Family Planning Advisory Council; the Perinatal Advisory Committee; the Genetic and Metabolic Diseases Advisory Committee; the Genetics Task Force of Illinois; Voices for Illinois Children; the Maternal and Child Health Training Program at the University of Illinois at Chicago School of Public Health; the Illinois Association of Public Health administrators; the Illinois Public Health Nursing Administrators Association; the Northern Illinois Public Health Consortium, Family Voices of Illinois; the Newborn Hearing Screening Advisory Committee; and DSCC's Family Advisory Council. A legal notice inviting public comment was published in the Edwardsville Intelligencer. The Department received comments from only one organization during the public comment period: the Family-to-Family Health Information and Education Center at The ARC of Illinois. This organization raised questions regarding the Department's plans to address the needs of children with special health care needs and/or chronic illnesses or disabilities in several areas of programming. Department and DSCC staff have been meeting with the Family-to-Family Health Information and Education Center to develop plans to address these concerns.

/2009/ The MCH Services Block Grant application was made available for public review/comment via posting on the Internet at www.dhs.state.il.us between June 5 and June 27, 2008. A draft was distributed to the same committees as in 2007. A legal notice inviting public comment was published in the Edwardsville Intelligencer. In commenting on the draft, the ARC of Illinois Family-to-Family Health Information and Education Center, strongly encouraged the Title V program to examine the Prioritization of Need for Services (PUNS) database operated by DHS and direct MCH services to the entire population of children with disabilities.

As of July 2008, 14,954 individuals were interviewed by developmental disability service providers for urgency of need for services. The service needs of these individuals were categorized accordingly: emergency (need immediate services), 2670; critical (need services within a year), 7776; and planning (need services within five years), 4508. These statistics were reported through the DHS Division of Developmental Disabilities' Prioritization of Urgency of Need for Services (PUNS) database. The database provides information of type of services needed as well as the urgency with which they are needed. Information regarding referrals and source of referrals is not gathered by PUNS. Nonetheless, the Division of Developmental Disabilities (DD) works with other programs within DHS as well as other departments to promote referrals to PUNS.//2009//

/2010/ The MCH Services Block Grant application was made available for public review/comment via posting on the Internet at www.dhs.state.il.us. A legal notice inviting public comment was published in the Arlington Heights Daily Herald. The DSCC Family Advisory Council (FAC) reviewed each of the Children with Special Health Care Needs Performance Measures throughout this year at Council meetings in preparation for submission. . Three members of the FAC submitted comments during the public review period. The concerns and questions presented in the comments are reflected throughout the narrative. In commenting on the draft, the ARC of Illinois Family-to-Family Health Information and Education Center, strongly encouraged the Title V program to examine the Prioritization of Urgency of Need for Services (PUNS) database operated by DHS and direct MCH services to the entire population of children with disabilities. The Title V program is preparing a formal response to the Arc of Illinois that detail among other things: 1)The status of PUNS outreach and referral; 2)The number of individuals informed of PUNS through department

*hotlines; 3)Whether Illinois' child health insurance programs place PUNS referrals; and
4)The mechanism for tracking PUNS referrals within the department. //2010//*

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ The State of Illinois evidenced significant improvement in several of its performance measures: the rate of birth for teenagers (NPM #8), the prevalence of childhood lead poisoning (SPM #5), and the proportion of children under 36 months of age in WIC or Family Case Management who received at least one developmental screening test (SPM #9). A new State Performance Measure on the percentage of females 15-24 years of age receiving services at Title X Family Planning clinics who received at least one test for Chlamydia (SPM #10) is included in this application. It replaces the original State Performance Measure #7 - the incidence of Chlamydia among adolescents and young adults. //2008//

/2008/ Illinois Department of Human Services (IDHS) will host a statewide Infant and Maternal Mortality Summit in Chicago on October 24-25, 2007. This summit will bring key stakeholders (including elected officials, community-based agencies, health care and service providers) together to develop and implement a statewide strategic plan to improve infant and maternal outcomes in Illinois. //2008//

/2008/ Statewide mortality data were released July 12, 2007 by the Illinois Department of Public Health (IDPH). Statistics available at this application's deadline are included in Form 12. A formal analysis of mortality statistics will be presented to HRSA at the MCH Services Block Grant application review meeting in August 2007 and submitted as an amendment to the application in September 2007. //2008//

/2009/ The Illinois Maternal and Child Health Coalition sponsored a two-part summit on Maternal and Infant Health in order to focus attention on the racial disparity in infant mortality and to develop new approaches to addressing this problem. The 10 broad strategies recommended by the summit include:

1) Increase access to comprehensive sex education including family planning; 2) Access to affordable health care for all across the lifespan; 3) Provide children's allowances i.e. universal income based supports similar to European countries; 4) Provide maternity/paternity paid leave; 5) Ensure the quality of prenatal and general healthcare in all communities; 6) Integration of case management systems and provide local resources for communities to develop systems of care; 7) End racially discriminative policies and practices in public institutions-such as education and housing, and criminal justice; 8) Maintain effective and efficient health data systems that provide timely health information that can be used to generate action; 9) Institute a public campaign to improve community mores in support of pregnant women; and 10) Advocate for community economic development in areas of employment, housing, and education in a manner that engages and empowers communities. //2009//

/2010/The 10-point strategic plan from Summits I & II was further developed into the Campaign to Save our Babies (CSOB). The CSOB devised a pilot project to implement the 10-point action plan in an incubator community; Englewood, a low income neighborhood on the south side of Chicago). In addition to the CSOB, our Title V agency in partnership with the Illinois Maternal and Child Health Coalition (IMCHC) applied for and was awarded funding to participate in the Partnership to Eliminate Disparities in Infant Mortality (PEDIM), Action Learning Collaborative (ALC), sponsored by CityMatCH, AMCHP, NHSA. Dr. Sullivan and Robyn Gabel (CEO of IMCHC) are the co-leaders of the Illinois Collaborative. Other partners includes Illinois' Healthy Start administrator, Jerry Wynn and representatives from the Chicago Department of Public Health and the University of Illinois

at Chicago.//2010//

/2010/ DSCC continues collaborating with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) to promote medical homes and support quality improvement teams in primary care practice sites. Building on the success of the Illinois Medical Home Project that was HRSA funded, ICAAP and DSCC are promoting a program called Building Community-based Medical Homes for Children funded by the Michael Reese Health Trust (3 year grant) and the Chicago Community Trust (1 year grant.) The program teaches how to set up effective medical home innovation teams; identify the patient population; include families in the QI process; make the practice accessible; make the practice family centered and culturally effective; provide planned, proactive care; develop written care plans for special needs patients; become a DSCC medical home provider and receive increased reimbursement; and participate in the National Committee for Quality Assurance's Physicians Practice Connection evaluation program. ICAAP and DSCC will also improve the availability of information about community resources to medical homes and families through activities of the HRSA grant for Integrated Community Systems that was recently approved for funding. //2010//

/2010/Illinois is currently in the process of conducting its 2011-2015 Needs Assessment. The major activities for the needs assessment are being guided by a workgroup of eight people from the Illinois Department of Human Services (DHS) and the UIC Division of Specialized Care for Children (DSCC). This group has met via conference call periodically since the spring of 2009 to plan the needs assessment process and direction.

The first major component of the needs assessment is convening of an "expert panel" to advise the internal workgroup on the needs assessment process, data analysis and interpretation, and prioritization. Professionals with expertise in various fields of maternal and child health were invited to serve on the expert panel after nomination by workgroup members. The final expert panel is composed of 12 professionals with expertise in areas such as perinatal health, adolescent medicine, developmental disabilities, and epidemiology. They are also diverse in their positions: physicians, nurses, academic faculty, advocates, epidemiologists, and a parent representative. The expert panel met for the first time in August 2009 to discuss the broad questions that should be addressed and to comment on the needs assessment process and timeline. The panel will meet again in November 2009 and January 2010.

The second component of the needs assessment is a series of community forums to be held throughout the state during October 2009. The purpose of the forums is to elicit information from stakeholders about ways to improve health services to women, children, and families. There will be separate provider and consumer forums at each of four locations (Chicago, DeKalb, Springfield, and Mount Vernon) to try to elicit diverse input. Consultants have been hired to facilitate the community forums and recruitment of participants is underway through the DHS regional administrators and DSCC regional offices.

Results of this process will form the basis of Illinois' maternal and child health needs assessment. Illinois expects to complete the needs assessment in advance of the opening session of the state legislature. The document will be shared with legislative members in an effort to influence future funding decisions.//2010//

III. State Overview

A. Overview

/2007/ All of Section III was rewritten for the FFY 2007 application.//2007//

Population. Illinois ranks fifth in the nation in population, with 12.8 million people, including 3.4 million children under the age of 18, according to Census Bureau's population estimates as of July 1, 2005. In the year 2005, there were approximately 2.7 million women in Illinois who were of childbearing age (15 to 44 years). In recent years, Illinois has averaged about 181,200 live births annually. An average of 43,600 pregnancies are aborted each year.

According to the 2002 National Survey of Children with Special Health Care Needs (CSHCN), there are about 379,436 CSHCN in Illinois, or 11.6 percent of children under 18 years of age. In comparison, the survey identified 9.4 million CSHCN nationally, or 12.8 percent of children under 18 years of age. The survey identified 323,385 Illinois households with a CSHCN, or 19.2 percent of the state's households. Twenty percent of all households in the nation had a CSHCN. DSCC serves approximately 23,000 CSHCN with their current resources.

/2009/ According to the 2005-2006 National Survey of Children with Special Health Care Needs (CSHCN), there are about 451,776 CSHCN in Illinois, or 13.9 percent of children under 18 years of age. In comparison, the survey identified 10.2 million CSHCN nationally, or 13.9 percent of children under 18 years of age. //2009//

/2010/There are no recent changes for 2010 unless there is a more recent survey that's preliminary. 2005-06 appears to be most recent as it was posted at website in 2008 by DHHS.//2010//

Sixty-six percent of the state's population resides in Chicago and the six "collar" counties that surround it in the northeast corner of the state, and two counties (Cook and DuPage) account for half of the state's population. Excluding Chicago, 26 cities of 50,000 or more in population account for over 2.1 million persons, or about 17 percent of the state's population. Using 2005 population estimates, there were 18 counties outside the collar counties whose populations exceeded 100,000. Other than these population centers, Illinois is characterized by rural areas. Using the USDA Rural-Urban Continuum classification scheme and 2004 population data, 66 of the 102 counties are considered rural. About two-thirds of Illinois' population (Chicago and the collar counties) is concentrated on less than ten percent of its land, while the majority of the state is characterized by small towns and farming areas.

/2010/ Using the U.S. Department of Agriculture (USDA) Rural-Urban Continuum classification scheme and 2007 population data, 9 of the 102 counties are considered "completely rural" or less than 2,500 urban population, either adjacent or not adjacent to a metropolitan area. . Another 57 counties are considered "urban" with a population of 12,500 to 19,999, either adjacent or not adjacent to a metropolitan area.//2010//

In 2005, the U.S. Census Bureau estimated that 79.5 percent of the state's population was Caucasian, 15.2 percent was African-American, 4 percent was Asian, Native Hawaiian or Other Pacific Islander, 0.3 percent was Native American, and 1.0 percent was multiracial; 14 percent of the state's population was of Hispanic origin. Chicago is home to more than half of the state's African-Americans and 49 percent of the state's Hispanic-Americans.

The size of Illinois' rural area is a significant geographic barrier to health care. The Illinois Department of Public Health's (IDPH) Center for Rural Health reports that there are 83 rural counties and 19 urban counties in Illinois. The Center further reports designation of Health

Professional Shortage Areas (HPSA's) by county, township, and Census tract. All but ten counties (92 percent of Illinois) have some category of HPSA designation: 36 are geographic; 42 are low-income population; and 14 are sub county level. This problem of provider distribution in rural areas creates barriers to care arising from problems with transportation, child care, hours of service, and related concerns. Families of CSHCN in some rural areas may have to travel three hours to access specialists' services.

/2008/ All but 22 counties (78 percent) of Illinois have some category of HPSA designation: 39 are geographic; 24 are low-income population; and 17 are sub county level. //2008//

/2010/ All but 6 counties (94 percent) of Illinois have some category of HPSA designation: 42 are geographic; 26 are low-income population; and 28 are sub county level.//2010//

Summary of Health Status. The most important health care needs of the state's population can be considered by population group:

/2008/ Recency of Vital Statistics data varies: 2004 for mortality statistics, and 2005 for natality statistics. //2008//

/2009/ Recency of Vital Statistics varies: 2005 for mortality statistics and 2006 for natality.//2009//

/2010/ Recency of Vital Statistics varies: 2006 for mortality statistics and 2007 for natality statistics. //2010//

Maternal and Infant Health

Early and continuous access to prenatal care remains a challenge. Overall, 81 percent of the pregnant women in Illinois initiate prenatal care in the first trimester, while 79 percent receive adequate care (using the Kotelchuck Index of adequate prenatal care) throughout pregnancy.

Illinois' infant mortality rate has declined steadily for the past decade, and has declined 25 percent since 1993. The rate of 7.3 per 1,000 for 2004 is the second-lowest for the State of Illinois. The state's 2003 rate (7.6 per 1,000) still compares unfavorably with the provisional rate for the nation as a whole (6.9 per 1,000). Significant racial disparities in infant mortality persist by racial and ethnic groups: the rate for African-Americans is more than twice that of Caucasians (2.5:1 in 2004). The 2003 rate for African-American babies dropped to 14.8 per 1,000 live births in 2004 from 15.6 in 2003. The Caucasian rate dropped from 6.1 per 1,000 live births in 2003 to 5.9 in 2004. Chicago's infant mortality rate fell to 8.4 deaths per 1,000 live births in 2004, down from 9.6 in 2004 and surpassing the previous low of 8.6 per 1,000 live births in 2002. The downstate infant mortality rate (all geographic areas outside the city of Chicago) rose slightly from 6.8 per 1,000 live births in 2003, to 6.9 in 2004.

A total of 180,665 infants were born to Illinois residents in 2004 and 1,317 infants did not live to their first birthday that year.

/2010/ Illinois' infant mortality rate has declined steadily for the past decade, and has declined 25 percent since 1993. The rate of 7.4 per 1,000 for 2006 suggests that the decline is plateauing between 7.4 and 7.2. Significant racial disparities in infant mortality persist between racial groups: the rate for African-Americans is more than twice that of Caucasians (2.4:1 in 2006). However, the gap is closing as African-American infant mortality continues to decrease and that for Caucasians remains stable. While Chicago's infant mortality figures suggest continued improvement, those for downstate (all geographic areas outside the city of Chicago) reported an increase especially compared to past years. This is due in part to the gentrification of Chicago.//2010//

/2008/ DHS and Illinois Department of Healthcare and Family Services (IDHFS) have partnered with private funders and have developed a pilot program in the North Lawndale and Austin

communities in Chicago to test a performance-based approach to reimbursement for intensive outreach to engage otherwise hard to reach women. The project Healthy Births for Healthy Communities was launched on July 1, 2006. //2008//

/2008/ Closing the Gap's Study of the Quality of Prenatal Care. This project allows IDHFS to perform an evaluation of the content and quality of medical care provided in Closing the Gap's target areas. Closing the Gap is funding the collection and preliminary analysis of medical record data. The Michael Reese Health Trust (MRHT) Partnership funds support a more in-depth analysis of the data by faculty from the University of Illinois at Chicago School of Public Health's Maternal and Child Health Training Program. //2008//

/2008/ Closing the Gap Medical Record Review. IDHFS and IDHS are working closely on this project. IDHFS, through its Peer Review Organization, is responsible for performing a prenatal care medical record review. Additionally, the MRHT provided grant funds to allow IDHFS to perform an evaluation of the content and quality of prenatal care in the Closing the Gap communities using the data from the medical record review. IDHFS is working with the University of Illinois at Chicago, School of Public Health to perform the evaluation. The medical record review, which began in November 2006, is currently in process. This project will result in development of a training curriculum to address issues identified in the evaluation. //2008//

/2010/ The medical record review was completed in 2008 and a final report of findings was issued. IDHS and IDHFS are working together on a plan to disseminate the findings of both studies to the provider community for the purpose of developing support for medical education recommendations and to develop strategies for closer coordination of primary care and obstetric/gynecological care.//2010//

/2008/ Behavioral Health Risk Assessment. IDHFS recently received a grant from the March of Dimes to implement a behavioral health risk assessment statewide, and is working with the Children's Research Triangle/National Training Institute Upstream to provide consultation and training services and to develop a comprehensive continuum of screening, assessment, brief intervention, and treatment of pregnant women at risk for substance abuse (alcohol, tobacco, and illicit drugs), depression, and domestic violence. //2008//

/2010/ A study sponsored by the Illinois Department of Children and Family Services and conducted by the University of Illinois found that recovery coaches can significantly reduce the number of substance-exposed births as well as help reunite substance-involved families, saving state child-welfare systems millions of dollars in foster-care and other placement costs. Families were randomly assigned to one of two treatment conditions. The mothers assigned to the control group during the five-year study received traditional child-welfare and substance-abuse services; the mothers assigned to the experimental group received traditional services plus the services of a recovery coach. The coaches--case workers with special training in addiction, relapse prevention, case management and counseling--focused on getting the mothers into substance-abuse treatment and keeping them there by engaging in face-to-face contacts in the family home and with treatment provider agencies. At the study's conclusion, 15 percent of the mothers assigned to the recovery-coach group had given birth to a subsequent substance-exposed infant compared with 21 percent of mothers assigned to the control group. (Science Daily: January 7, 2009)//2010//

Childhood Health

According to CDC's National Immunization Survey data, the proportion of children in Illinois who are fully immunized reached 83.7 percent by December 2004 (the most recent data available at the time of submission).

/2008/ According to CDC's National Immunization Survey data, the proportion of children ages 19-35 months in Illinois who are immunized with the 4/3/3/1 series reached 84.8 percent by

December 2005 (the most recent data available at the time of submission). //2008//

/2010/ According to CDC's National Immunization Survey data, the proportion of children ages 19 - 35 months in Illinois who are immunized with the 4/3/1/3/3 series as a minimum standard reached 79.8% as reported for the 2nd quarter in 2008. In Illinois, the same series has been measured at 78.9% including the city of Chicago. Excluding the city, the level is reported as 80%, slightly above the national report.//2010//

During FFY 2004 (the most recent data available), more Medicaid-eligible children received well child screenings than in previous years, based on the Center for Medicare and Medicaid Services (CMS) definitions. Approximately 1,221,600 children were eligible for Medicaid in FFY'04 and the overall participation ratio was 72.3 percent.

/2008/ The IDHFS is in the process of updating the Central Management System (CMS) 416 report at this time, and is unable to provide the number of Medicaid-eligible children and actual participation ratio based on the CMS definition. However, based on the Department's Medicaid claims data, there were 1,369,135 Medicaid-enrolled children for FFY05 and 1,461,933 Medicaid-enrolled children for FFY06. //2008//

/2010/ The 2008 CMS-416 participant ratio is 67.0 percent. This ratio is provisional since providers have up to one year after the services is delivered to submit claims. Based on IDHFS' Medicaid claims data, there were 1,471,976 Medicaid-enrolled children eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program services during 2008. This is a percent change increase of +5.7 compared to 2007 (n=1,392,361).//2010//

Adolescent Health

The number of teen births has declined by 16 percent in the last five years, and the proportion of infants born to teenage mothers has declined by 16 percent at the same time. There were 17,819 births to teenagers in 2004; this represented 9.9 percent of all live births in the state. More than 88 percent of these young mothers were unmarried at the time they gave birth, posing a significant challenge for obtaining and maintaining economic self-sufficiency.

While the number of teen births decreased among Caucasian and African-American teens between 2000 and 2004, the number of births in that time period to Hispanic teen mothers peaked at 6,004 in 2001 and then dropped to 5,561 in 2004. While the number of Hispanic teen births in the city of Chicago decreased by 431 births between 2000 and 2004, the number downstate increased by 89 births. Most of these births occurred in the metropolitan counties surrounding the city of Chicago.

Reproductive Health

Illinois has about 706,500 women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program had enough resources to serve only 21 percent of the women in need during CY'04.

Children with Special Health Care Needs

Through increasing awareness efforts, the Medical Home concept has now become a part of several grant activities in Illinois that involve quality improvement processes in physician practices, improving access to a Medical Home in the Head Start Association and Epilepsy Foundation, a Care Coordination Organizer funded through the American Legion, and a web-based information source for families and physicians about chronic health conditions managed in the primary care setting. Increased family and physician awareness of the Medical Home concept was accomplished through presentations at hospital grand rounds, in-office educational programs, new articles, various family programs, and word of mouth. For additional information on Medical Home grant activities, see Federal Performance Measure 3.

/2008/ DSCC has become involved in several activities that focus on spreading the Medical

Home concept in multiple situations. In 2004, the Illinois Chapter of the American Academy of Pediatrics (ICAAP) obtained a \$1 million four-year grant to assist pediatric practices to implement a quality improvement process using the medical home model as the foundation of care. Nearly 20 practices participate in this grant activity. The DSCC Director is the principal investigator for this grant. DSCC participated in the second National Initiative for Children's Healthcare Quality (NICHQ) Medical Home Learning Collaborative as well as the NICHQ Medical Home and Epilepsy Learning Collaborative. DSCC has also provided administrative and technical support to the national American Academy of Pediatricians (AAP) for development of a website for families to create a Medical Home Organizer. Families will be able to choose the separate contents from 20 state care organizers to customize their own child care notebook. The organizer will be available on the AAP Medical Home website under parent tools. DSCC continues to promote family and physician awareness of the Medical Home concept through presentation, the DSCC website, publications, brochures, and posters. //2008//

/2009/ In Illinois, the four-year Maternal Child Health Bureau grant will be ending in June 2008. This grant activity is demonstrating the value of a trained facilitator to structure quality improvement in a primary care practice setting. Other medical home activities include the development of an online "build your own care notebook" on the AAP www.medicalhomeinfo.org website. This is complete with a six-part tutorial to assist families and workshop facilitators to navigate through the website. The Arc of Illinois' website that houses the LifeSpan Database has now been expanded to include a wide variety of categories to list community resources for CSHCN.

Staff of the Genetics Program at IDPH have been involved with a seven state, regional HRSA funded project, the Region 4 Genetics Collaborative, focused on linking children with heritable disorders with a Medical Home. //2009//

The Illinois Interagency Coordinating Council on Transition has focused efforts on cross-agency training for member agencies on transition planning and services to improve access to transition services for youth with disabilities and their families. IDHS, IDPH, and DSCC have focused efforts on improving screening, evaluations, interventions, and reporting for newborns through the Newborn Hearing Screening Program. To improve access to care, DSCC is involved in the development of a Region 4 genetics website to increase physician and family awareness of newborn screening information and resources. Illinois screens newborns using tandem mass spectrometry for all conditions except cystic fibrosis.

/2009/ To improve access to care, DSCC is involved in the development of a Region 4 genetics website to increase physician and family awareness of newborn screening information and resources. Illinois screens newborns using tandem mass spectrometry for all conditions except cystic fibrosis.//2009//

/2008/ The Medical Home information website as part of the Region 4 Genetics Collaborative is for parents and physicians and is located at this site: www.genetics4collaborative.org. //2008//

/2008/ DSCC is collaborating with ARC of Illinois Life Span Database to expand the listing of community resources to all 102 counties in Illinois. DSCC staff, the Brain & Spinal Cord Injury Association, and the Autism Project are collaboratively contributing their respective lists of community resources to the database. Families and Medical Home providers can use this website to provide more comprehensive care for children and youth. //2008//

/2008/ Staff of the ARC of Illinois Family-to-Family Health Information and Education Center and the DCHP engaged in a series of meetings to develop strategies for reaching as many families as possible whose children have special health care needs but do not fall within the medical eligibility criteria for DSCC. //2008//

/2009/The staff of the Family to Family Health Information and Education Center will conduct

workshops throughout the state to assist families and other professionals to navigate through the AAP www.medicalhomeinfo.org website on "Building Your Own Care Notebook". They will also participate in training Family Voices representatives throughout the states to facilitate workshops in their respective states. This training will take place in May 2008.

Staff of the Arc of Illinois Family to Family Health Information and Education Center received a small grant from Family Voices that helped to support a workshop for families on the various medical and waiver programs for children with special needs administered by the Department of Healthcare and Family Services.//2009//

Budget Highlights

/2009/ Highlights of the FY2008 budget are cost of living increases. FCM service providers received a 3% cost of living increase. The \$1.3 million increase was the first to be awarded in over a decade. Other providers that received cost of living increases were those delivering GP and TIPCM services, in total \$250,000 and \$150,000 respectively. The Department was awarded a \$1 million contract from Northrop Grumman to implement a Fetal Alcohol Spectrum Disorder Prevention program statewide over the next five years. The Brief Intervention for Alcohol Use will become part of the Department's existing WIC and FCM services to pregnant women. A demonstration of the project will be conducted in Rockford, IL through the Winnebago CHD for the first two years of the contract. The program will then be implemented throughout the state during the remaining years of the contract. //2009//

Legislative Update

/2010/ In December 2007, IDHS, IDHFS and IDPH released an Informational Notice to all affected HFS-enrolled providers to inform them of the new Act and to provide resources to assist providers in screening, assessment, treatment and referral for perinatal depression. The agencies continue to work together in developing policies and procedures to assist providers in meeting the requirements of the Act.//2010//

/2009/ Public Act 95-0422 amends the School Code by changing the physical examination requirement for students from "prior to entering 5th grade" to "prior to entering 6th grade." The Illinois Department of Public Health met with the Illinois State Board of Education to discuss the implementation of the Act and agreed that because the 2007-2008 school year had already commenced, the legislative change would be deferred until the 2008-2009. Public Act 95-0469, the Perinatal Mental Health Disorders Prevention and Treatment Act, became law January 1, 2008. The purpose of the law is to increase awareness and to promote early detection and treatment of perinatal disorders. Telepsychiatry: Public Act 095-0016 effective 7/18/07 authorizes IDHFS to reimburse psychiatrists provided by Telepsychiatry. Since many persons needing mental health care live long distances from a psychiatrist, this Act takes a step toward addressing the shortage of psychiatrists working in rural communities. Since signing, IDHFS has been developing the rule and procedures needed to implement this Act.//2009//

Health Care Financing. Enrollment in Health Maintenance Organizations (HMOs) continues to decline. In 2005 (the most recent data available), 12.5 percent of the state's population was covered by an HMO. There were 29 licensed HMOs in the state in 2004. The ten largest HMOs covered 1.5 million persons in 2005, a 38 percent decrease from the 1999 peak of 2.6 million. Four of the ten largest plans have enrollments in excess of 100,000 persons: Health Care Service Corporation, Health Alliance Medical Plans, Humana Health Plan and Unicare Health Plans. These four HMOs have enrolled about 1.1 million persons, or 70 percent of the total. Changes in hospital ownership have not affected affiliation agreements for the regionalized perinatal care system. The number of hospitals providing obstetrical care has been declining; currently 133 hospitals are licensed to provide this service.

Three Managed Care Organizations (MCOs) participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves

certain Title XIX and Title XXI participants in St. Clair, Madison, Perry, Randolph and Washington Counties. As of March 2006, these managed care programs served 149,497 people, a decrease of more than 25,000 people since March 2004.

/2008/ Two Managed Care Organizations (MCOs) participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves certain Title XIX and Title XXI participants in St. Clair, Madison, Perry, Randolph, and Washington Counties. As of March 2007, these managed care programs served 129,077 people, a decrease of more than 20,000 people since March 2006. //2008//

/2009/As of June 2008, these managed care programs served 174,610 people, an increase of more than 28,000 people since June 2006. The increase is due to the implementation of the Primary Care Case Management program, where most IDHFS participants in Illinois have to choose a medical home.//2009//

Children in Illinois may receive publically-subsidized health insurance through Governor Blagojevich's "All Kids" initiative. All Kids has six components: All Kids Moms and Babies - coverage through Title XIX (Medicaid) for pregnant women and their infants up to age one year with income up to 200 percent of the FPL. All Kids Assist - coverage through Title XIX and Title XXI for children through age 18 with family income at or below 133 percent of the FPL. All Kids Share - coverage through a combination of Title XIX and Title XXI for uninsured children through age 18 with family income above 133 percent and at or below 150 percent of the FPL. Co-payments of \$2 per prescription and \$2 per medical visit are required, except for well-child visits and immunizations. All Kids Premium - offers coverage through a combination of Title XIX and Title XXI for uninsured children through age 18 with family income above 150 percent and at or below 200 percent of the FPL. Monthly premiums of \$15 for one family member, \$25 for two, \$30 for three, \$35 for four and \$40 for five or more family members are required. Co-payments of \$5 per medical visit, \$5 for brand name prescriptions and \$3 for generic prescriptions as well as an optional \$25 co-payment for non-emergency use of hospital emergency room services. There are no co-payments for well child visits or immunizations. Co-payments under both plans ("Share" and "Premium") are capped at \$100 per family per year. All Kids Rebate - uses Title XIX and Title XXI funds provided through a Health Insurance Flexibility Accounting demonstration program (HIFA) waiver to provide a payment to families with private health insurance coverage for their children. It allows a maximum reimbursement up to \$75 per eligible child per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physician's services and hospitalization. Children through age 18 with family income above 133 percent, and at or below 200 percent of the FPL are eligible. All Kids Expansion -- provides medical benefits for uninsured children under age 19 regardless of income or immigration status. The Illinois Department of Healthcare and Family Services is implementing both Disease Management and Primary Care Case Management to reduce Medicaid expenditures and provide the resources necessary for the implementation of the All Kids Expansion.

/2008/ All Kids Expansion - provides medical benefits for children under age 19 regardless of income or immigration status. It provides state funded health insurance to uninsured children through age 18 (parental income is not counted for children who are age 18) whose family income is greater than 200 percent of the FPL, and to children through age 18 who do not meet immigration requirements. Families with income greater than 200 percent of the FPL will pay co-pays and monthly premiums for All Kids Premium Levels 2 through 8 based on monthly income. The monthly premium per child under Premium Level 2 is \$40 with a maximum monthly premium of \$80 for two or more children, for Premium Level 3 is \$70 with a maximum monthly premium of \$140 for two or more children, for Premium Level 4 is \$100, with a maximum monthly premium of \$200 for two or more children, Premium Level 5 is \$150, Premium Level 6 is \$200, Premium Level 7 is \$250, and Premium Level 8 is \$300. Co-pays for services are based on Premium Level. Physician visits range from \$10 to \$25 per visit, generic prescription drugs range from \$3 to \$12 per prescription, brand name prescription drugs range from \$7 to \$28 per prescription,

inpatient hospital admissions range from \$200 (25 percent of the All Kids payment rate) and outpatient services range from 5 - 25 percent of the All Kids payment rate. Emergency room services range from \$30 to \$100 per visit. Families at Premium Levels 2-7 have an annual out-of-pocket maximum for hospital services ranging from \$500 to \$5,000 per child per year. All Kids expansion covers the same services as All Kids Share and All Kids Premium. //2008//

/2008/ Disease Management. "Your Healthcare Plus" is the new Disease Management program of the IDHFS beginning July 1, 2006. Your Healthcare Plus supports medical providers with the management of patients with complex chronic illnesses. IDHFS has commissioned McKesson Health Solutions to administer the program. Provider and patient participation is voluntary; individuals eligible for the Your Healthcare Plus Program will have the right to "opt out." Currently, the program serves approximately 220,000 individuals which includes: 1) Disabled adults who have been diagnosed with a chronic condition such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, end stage renal disease, hemophilia, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), malignancy, mental health, or other co-occurring conditions; 2) children and adults who have persistent asthma (utilizing the Health plan Employer Data and Information Set (HEDIS) definition); and 3) children and adults who are frequent emergency room users (defined as six or more visits a year.) //2008//

/2008/ New Program: Illinois Health Connect. In July 2006, the State of Illinois implemented a new program called Illinois Health Connect, which is a statewide Primary Care Case Management (PCCM) Program for most persons covered by an IDHFS Medical program. People who are enrolled in Illinois Health Connect will have a Medical Home through a Primary Care Provider (PCP). //2008//

/2008/ Through creating Medical Homes, the State expects to improve the quality of IDHFS Medical Program participant's health care, while at the same time creating cost savings. Potential enrollees will choose a PCP who will coordinate and manage their care by ensuring that they get primary and preventive health care services, including immunizations and health screenings, and that they avoid unnecessary emergency room visits and hospitalizations. Having a single PCP will also help people with chronic conditions like asthma, heart disease or diabetes to get the treatment and ongoing care they need to minimize the need for hospital care. PCPs will make referrals to specialists for additional care or tests as needed. //2008//

/2008/ Over 1.5 million patients including one million children enrolled in All Kids, 40,000 adults enrolled in FamilyCare and 100,000 elderly or disabled adults are eligible for Illinois Health Connect and will choose one PCP to act as their medical home. Physicians willing to provide a medical home for patients must enroll as an Illinois Health Connect PCP. //2008//

/2008/ The mandatory phase of Illinois Health Connect began in February 2007 in Cook and the collar counties. To date, there are over 2,200 providers participating as PCPs with a capacity to serve over three million patients. As Illinois Health Connect is expanded throughout the rest of Illinois, additional PCPs are being recruited. //2008//

/2009/ Illinois Health Connect is mandatory statewide. With the completion of the statewide mandatory enrollment, 96% of the eligible participants picked or were assigned to a PCP for their medical home. As new participants become eligible for Illinois Health Connect, they will have approximately 60 days to select a medical home or one will be assigned. To date, July 1, 2008, there are over 5,300 providers participating as PCPs in Illinois health Connect with a capacity to serve over five million patients. Illinois Health Connect will continue to expand the provider network through the on-going recruitment of providers not currently enrolled as Illinois Health Connect PCPs. //2009//

Illinois also provides presumptive eligibility for children under both Title XIX and Title XXI.

Illinois' FamilyCare program provides health insurance coverage to parents with income equal to or less than 185 percent of the FPL. Governor Blagojevich increased the eligibility threshold for FamilyCare to 133 percent of the FPL in September 2004 and from 133 to 185 of the FPL in January 2006. FamilyCare is financed with a combination of Title XIX and Title XXI funds and authorized by a Title XXI waiver.

FamilyCare has four components: FamilyCare Assist provides coverage for parents with incomes at or below 133 percent of the FPL. Co-payments of \$2 per medical visit and \$3 for brand-name prescriptions are required. FamilyCare Share provides coverage for parents with income above 133 percent and less than or equal to 150 percent of the FPL. Co-payments of \$2 per prescription and \$2 per medical visit are required. Co-payments are capped at \$100 per year per family. FamilyCare Premium provides coverage for parents with incomes above 150 percent and less than or equal to 185 percent of the FPL. Monthly premiums of \$15 for one family member, \$25 for two family members, \$30 for three family members, \$35 for four family members and \$40 for five or more family members are required. Co-payments of \$5 per medical visit, \$5 per brand-name prescription, \$3 per generic prescription and \$25 for non-emergency use of hospital emergency services are required. Co-payments are capped at \$100 per family per year. FamilyCare Rebate provides a health insurance premium subsidy to families with private health insurance coverage. It allows a maximum reimbursement of up to \$75 per eligible family member per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physicians services and hospitalization. Eligible adults in families with incomes above 133 percent and less than or equal to 185 percent of the FPL are eligible.

In 2004, IDHFS submitted a report to the Governor and the General Assembly making recommendations on optional services for pregnant women that could be implemented under the Medicaid program to improve birth outcomes. Over the past two years, IDHFS has used that report as a guide to implement initiatives aimed at improving birth outcomes in Illinois. Since the original report was issued, many new initiatives have been implemented and Illinois has seen improvements in birth outcomes. Other initiatives will be implemented over the next two years. The status of the priority recommendations from the initial report are summarized below. The original report and the 2006 update are available at www.hfsillinois.com/mch/report.html.

/2008/ IDHFS continues to use the recommendations contained in the 2004 Report to the Governor and the General Assembly to implement initiatives aimed at improving birth outcomes. The original report and the 2006 update are available at www.hfsillinois.com/mch/report.html. Priority initiatives aimed at improving birth outcomes include the following: //2008//

/2009/ The 2008 update of the Report to the Governor and its earlier versions are available at www.hfsillinois.com/mch/report.html. //2009//

Planned Pregnancies

Two amendments to expand the Illinois Healthy Women (IWH) family planning waiver have been submitted to the federal government for approval. The first amendment requested federal financial participation in the cost of multivitamins and folic acid, and coverage of eligible women who are leaving the SCHIP program. The latter provision was approved; the former was denied. The second amendment requested expansion of coverage to include women at or below 200 percent of the FPL, regardless of their prior enrollment in Medicaid. Disposition of this amendment is pending. FamilyCare has been expanded incrementally to its current standard of 185 percent of the FPL, effective January 1, 2006. Work has begun on a new interconceptional care model targeting women who have experienced a fetal or neonatal loss, or had a premature or low birth weight infant. Reimbursement for preconceptional risk assessment will be implemented during 2006.

Mental Health During the Perinatal Period

A statewide perinatal mental health consultation services has been operating since 2004.

Reimbursement for perinatal depression screening has been available since December 2004. Local health departments and other providers have been trained on how to use the Edinburgh Perinatal Depression Scale. A client brochure was developed and distributed to raise awareness of perinatal depression. The IDHFS web site includes treatment and referral resources for clients and providers. The state's toll-free hotlines have been provided with information on perinatal depression, including referral resources. A Perinatal Depression Coordination project has been implemented to coordinate perinatal depression services statewide.

/2008/ The University of Illinois at Chicago (UIC) is working with IDHFS to develop two alternative treatment options for perinatal depression to address limited treatment resources in the state. The first option is a "step care" disease management protocol for treatment of perinatal depression in primary care settings and an accompanying quality monitoring process. The "step care" approach has been designed based on a disease management model. The "step care" approach gives providers the training and tools they need to successfully assess and treat perinatal depression and to refer women with greater symptom severity and/or insufficient treatment response. //2008//

/2008/ The second approach is a self-care tool for women experiencing perinatal depression. When medication is prescribed to treat perinatal depression, there are often other issues that are not being addressed, either due to lack of available resources, because the woman is not interested or is unable to access the services, or because services were not successful in the past. The self-care tool will provide women with suggestions for dealing with a variety of issues related to perinatal depression. //2008//

/2009/ As of September 2007, the UIC Peripartum Mental Health Consultation Service has trained more than 3,700 providers at workshops and presentations. The participants included: family medicine physicians (12.7 percent), obstetricians/gynecologists (10.6 percent), pediatricians (8.4 percent), nurses (40.8 percent), and other (27.5 percent). In addition, IDHFS has identified high-volume provider clinics statewide that are not yet billing for depression screening and UIC is targeting those sites for training. //2009//

/2010/ A Perinatal Antidepressant Medications Chart has been developed and made available to providers who treat women experiencing perinatal depression. The chart summarizes data about risks and benefits of prescription antidepressant medications during pregnancy and breastfeeding.//2010//

A statewide 24-hour Crisis Hotline is available for women experiencing perinatal depression. The hotline, 1-866-364-MOMS (1-866-364-6667), is operated by NorthShore University HealthSystem. The hotline provides crisis assessment, counseling and referral to local mental health services or emergency services. //2010//

Smoking Cessation

IDHFS has partnered with IDHS and IDPH to promote the Illinois Tobacco Quitline. Smoking cessation resources will be posted on IDHFS' web site. A client notice was mailed in November 2005 to inform beneficiaries of the availability of the Illinois Tobacco Quitline. This was followed by a provider notice in December 2005 to encourage providers to screen for tobacco use and provide treatment and referral to the Illinois Tobacco Quitline.

/2008/ MRHT awarded IDHFS a grant to fund a smoking cessation initiative to provide one-on-one peer counseling to pregnant women who smoke. IDHFS is in the process of engaging a smoking cessation expert to train three outreach workers who will provide peer counseling on smoking cessation in certain communities in Chicago. In addition, a smoking cessation patient survey is planned for 2007. //2008//

Certified Nurse Midwives are one of four advanced practice nursing (APN) specialties

recognized under the Medical Assistance program (Title XIX, Title XXI and their related components) and eligible for reimbursement for services rendered. Effective January 1, 2006, all APNs (except psychiatric APNs) are reimbursed at the rate paid to physicians and are eligible to receive the enhanced rate available to "MCH providers." This may expand access to nurse midwifery across the state. This is particularly important in rural areas.

Lactation Counseling

A client notice was mailed in December 2005 to inform women of the benefits of breastfeeding and of the availability of breastfeeding education, counseling and support services available through the WIC program, the availability of breast pumps, and a toll-free hotline number for peer-to-peer breastfeeding support and counseling. This was followed by a provider notice in January 2006 containing similar information.

/2008/ To assist clients in procuring a breastpump through IDHFS, IDHS has developed a statewide list of medical providers carrying breastpumps. Procedures describing the process and requirements to receive a pump have been developed and shared with all providers. //2008//

/2009/All eligible clients can receive a double electric breast pump suitable for women periodically separated from their baby through the IDHFS durable medical equipment program. Education on the use of the pump, milk storage guidelines, etc. is provided by WIC while the pump is delivered directly to the client. Procedures describing the process and requirements to receive a pump have been developed and shared with all providers. //2009//

Case Management

IDHS and IDHFS are partnering with private funders to develop a pilot program in certain Chicago communities to test a performance-based approach to reimbursement for intensive outreach to engage otherwise hard-to-reach women.

Michael Reese Health Trust Partnership Projects. In December 2004, the Michael Reese Health Trust (MRHT) awarded IDHFS \$400,000 to support three projects for a two-year period, January 1, 2005 through December 31, 2006. Each of the projects is designed to be a pilot with an evaluation component to identify issues affecting quality of care or test the efficacy of a particular intervention in improving birth and health outcomes.

Closing the Gap's Study of the Quality of Prenatal Care. This project allows IDHFS to perform an evaluation of the content and quality of medical care provided in Closing the Gap's target areas. Closing the Gap is funding the collection and preliminary analysis of medical record data. The MRHT Partnership funds support a more in-depth analysis of the data by faculty from the University of Illinois at Chicago School of Public Health's Maternal and Child Health Training Program.

Fluoride Varnish for Young Children./Bright Smiles from Birth. IDPH, IDHFS and the IL Chapter American Academy of Pediatrics implemented a pilot project to train physicians in Chicago, the surrounding counties, and to Federally Qualified Health Centers in other parts of the State to apply fluoride varnish to young children (under age three who have at least four erupted teeth) in the course of regular well-child visits and to evaluate this practice to determine its efficacy in improving oral health. The MRHT Partnership funds pay for the application of fluoride varnish and the program evaluation. Provider training is supported by a grant from the federal Health Resources and Services Administration. Additional information on this project is reported under State Performance Measure 4.

The Perinatal Depression Coordination Project involves the statewide expansion and coordination of perinatal depression services to develop a comprehensive approach to addressing perinatal depression for women enrolled in IDHFS' medical programs and

builds upon the work of the Governor's Task Force on Perinatal Depression. With Michael Reese Health Trust Partnership funds, IDHFS has executed an interagency agreement with the UIC Peripartum Mental Health Consultation Service to continue perinatal depression consultation services for an additional year, coordinate the consultation services with other perinatal services throughout the state, including 24-hour client hotline and development of referral resources, coordinate perinatal depression efforts with the efforts of other initiatives designed to promote the health mental development of young children, evaluate the effectiveness of coordinated, comprehensive approach to perinatal depression and work toward a sustainable system of perinatal depression services.

Assuring Better Child Health and Development (ABCD) II. In the fall of 2003, IDHFS was selected to participate in a three-year initiative sponsored by the Commonwealth Fund and the National Academy for State Health Policy. This initiative, Assuring Better Child Health and Development II, known in Illinois as Healthy Beginnings, is designed to improve the social and emotional well-being of young children by strengthening the capacity of Illinois' Medicaid program to promote children's healthy mental development, including screening for perinatal depression. Four other states (California, Iowa, Minnesota and Utah) participate in ABCD-II. The MRHT funds the Illinois project.

Through a grant agreement with IDHFS, the Ounce of Prevention Fund (the Ounce) provides assistance in the administration of this initiative. Additionally, the Ounce subcontracts with other organizations, including the Illinois Chapter of the American Academy of Pediatrics, the Illinois Academy of Family Physicians, the Erikson Institute and the Illinois Association for Infant Mental Health. Other state agencies, advocacy groups and providers also serve on advisory committees and subcommittees to direct and implement the project.

January 2004 marked the beginning of year one of this initiative and focused primarily on organizational and program design. Year two focused on the selection of four pilot sites, and provided training to those sites on the importance of developmental screening for children under three years of age and perinatal depression screening for mothers. The role of the pilot sites is to test best practices on how to integrate a social emotional component into primary health care and explore how Medicaid can promote children's healthy mental development. Each site was provide the Ages and Stages Questionnaire developmental screening tool, as well as the Ages and Stages Questionnaire / Social and Emotional scale at the time of their training. Each site was also trained on screening for maternal depression for mothers up to one year postpartum. During year three (2006), successful strategies learned from the pilot sites will be extended to other areas of the state. Further, a web-based training module for providers will be implemented, and an additional 40 minute training presentation is planned. In addition, IDHFS is planning to partner with the Enhancing Developmentally Oriented Primary Care (EDOPC) project. This project will also assist providers in assuring developmental screening and developmentally oriented care through the provision of technical assistance.

/2008/ On March 8, 2006, MRHT awarded \$300,000 to the IDHFS in support of the "Enhancing Developmentally Oriented Primary Care" project. In 2007, IDHFS received an additional \$139,787 from the Illinois Children's Healthcare Foundation (ICHF) allowing the extension of the program through 2008. Partners in the project include: the Advocate Health Care Healthy Steps Program, the Illinois Academy of Family Physicians (IAFP), the ICAAP and the Ounce of Prevention. //2008//

/2008/ The overall goal of EDOPC is to identify and overcome the barriers that pediatric primary care providers face in conducting developmental, social-emotional, postpartum depression, and domestic violence screenings, making appropriate referrals and attending to parents' developmental concerns. The EDOPC project helps Illinois' pediatric care providers through training, technical assistance and community support, and by

implementing strategies to effectively provide developmentally oriented primary care. The EDOPC project coordinates with ABCD and the Perinatal Depression coordination project and provides technical assistance to providers. //2008//

//2009/DHS MCH Nurse Consultants and FCM Coordinator are working with EDOPC project to identify potential training sites throughout Illinois on Healthy Steps model of care, after receiving training themselves in November 2007 and January 2008. They are going out into communities across the state, working with AOK networks, FQHC's , local health departments and private provider practices. A training is planned for Region 1 and 2 providers in May and June 2008. //2009//

The Illinois Healthy Women (IHW) program is a five-year federal demonstration waiver to provide basic women's health care services, including family planning, to eligible women when they lose coverage under one of the IDHFS' Medical Assistance programs. Implementation began in April 2004. Women who are eligible for the program are systematically selected as they lose Medicaid coverage. Eligible women automatically receive a mailing about the program that includes a 3-month eligibility card, a program description and an enrollment form. A 12-month eligibility card is issued when the enrollment form is completed and returned. Under the application process, women who are at or below 200 percent of FPL can submit an application. Women who are not eligible for IHW are referred to the DHS Family Planning program for assistance.

This expansion of IHW will serve more women, allowing IDHS to use Title X funds to serve individuals who do not qualify for IHW (e.g., undocumented residents, men, women under 19 and over 44 years of age). It is estimated that approximately 44,400 additional women will be covered under this expansion.

//2010/ IHW was implemented as a five-year waiver in April 2004. A renewal application for an additional three years was submitted to CMS in October 2008. As of June 2009, IDHFS received a 60 day extension (August 31, 2009) to the IHW waiver. CMS is processing the three-year renewal request. Informal feedback from initial reviews is positive. The delays in processing is attributed to the transition of administrations at the federal level. IDHFS anticipates receiving approval of the renewal with the extension period. //2010//

On February 19, 2004, the Illinois Department of Public Aid (as it was then known) submitted an amendment to the federal Centers for Medicare and Medicaid Services to request federal financial participation in the cost of multivitamins and folic acid and coverage of eligible women in the waiver who are leaving the SCHIP program. On March 28, 2006, IDHFS received approval to include women leaving the SCHIP program who are otherwise eligible for IHW in the waiver. However, the request for federal matching funds for the cost of multivitamins and folic acid was denied.

The Department of Public Aid submitted a second amendment on July 13, 2005, to request expansion of coverage to include women at or below 200 percent of the FPL, regardless of their prior enrollment in Medicaid. An expansion of IHW would serve more women, allowing IDHS to use Title X funds to serve individuals who do not qualify for IHW (e.g., undocumented residents, men, women under 19 and over 45 years of age). It is estimated that approximately 48,000 additional women will be covered under this expansion when it is approved by the Center for Medicare and Medicaid Services.

//2008/ The IHW family planning waiver expansion is being implemented in May 2007. The program will allow women to apply for coverage. They will be eligible if they: a) are at least 19, and no older than 44; b) are a U.S. citizen or legal permanent resident with a Social Security number; c) live in Illinois; d) meet the income guidelines; e) have no health insurance coverage for birth control; and f) are currently not pregnant. If the woman is pregnant, she is advised to apply for Moms & Babies by calling 1-866-ALLKIDS (1-866-255-5437). A preconceptional risk

assessment tool is being piloted. //2008//

Settlement of Memisovski, et al., v. Maram, et al. The IDHFS and IDHS have signed a consent decree with the plaintiffs to settle the "Memisovski" lawsuit. The suit was a class action brought on March 23, 1992 on behalf of the Class of children in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medicaid program. The lawsuit alleged that IDHFS and IDHS violated the rights of the children in the Class by failing to provide these children with access to medical care and services to an extent at least equal to that available to the general population in the geographic area and by failing to provide them with adequate Early and Periodic Screening, Diagnosis and Treatment services. After trial, in which the Class members prevailed, the parties negotiated and signed a Consent Decree to resolve the lawsuit. The general provisions of the Decree include rate increases for "MCH providers" (physicians who agree to specific terms authorized by the OBRA'89 legislation for increased Medicaid reimbursement) and dentists, revision of Federally Qualified Health Centers rates, bonus payments for providers who meet EPSDT requirements and enhanced communication with providers and families. The rate increases were implemented on January 1, 2006.

Service Delivery System. With the exception of the Teen Parent Services program in part of Chicago, all of the primary and preventive care services in Illinois' Title V program are provided by IDHS or IDPH grantees. Most often, these are local health departments. Community Health Centers also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants, children, and adolescents.

Local Health Departments were first established in Illinois by "AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same" (70 ILCS 905/1, effective July 1, 1917). Municipal health departments are governed by Section 17 of the Illinois Municipal Code of 1961 (65 ILCS 5/11-17-1). The statutory base for county and multiple county health departments (55 ILCS 5/5-25001) was revised July 1, 1990. Local health departments in Illinois are all tax supported to some degree. For county health departments, a local tax levy of as much as 0.1 percent of the assessed value of all taxable property in the county can be instituted through referendum; the actual rate is set, up to the legal maximum, through a vote of the county board (55 ILCS 5/5-25003 and 55 ILCS 5/5-25004). As of July 1, 2004, there were 46 "resolution" health departments (those established by resolution of a county board) and 48 "referendum" health departments. These health departments serve 99.6 percent of Illinois' population.

/2008/ these health departments serve 99.7 percent of Illinois' population. //2008//

Community Health Centers. The Illinois Primary Health Care Association reports there are 155 Community Health Centers, Federally Qualified Health Centers or Healthy Schools Health Communities grantees. Many of these centers are maternal and child health grantee agencies providing primary medical care, dental care services, mental health/substance abuse services, obstetrical and gynecological care, or other professional services. Individual FQHCs receive grants for many MCH programs. The most significant collaboration is in the Chicago Healthy Start Initiative. The Winfield Moody Health Center, the Erie Family Health Center and Henry Booth House are the medical partners for three of the four Healthy Start Family Centers. Erie Family Health Center, Lawndale Christian Health Center, and the Chicago Department of Public Health implement the Targeted Intensive Prenatal Case Management project in the city of Chicago. The Southern Illinois Healthcare Foundation is a lead agency for HealthWorks of Illinois. The Department is working with Access Community Health Network and with the Chicago Department of Public Health on the "Closing the Gap" initiative and with Lawndale Christian Health Center and PCC Wellness on the new Healthy Births for Healthy Communities project.

/2008/ The Illinois Primary Health Care Association reports there are now 281 Community Health Centers, Federally Qualified Health Centers, or Healthy Schools Healthy Communities grantees. //2008//

State-Level Initiatives. Three special initiatives at the state level will affect the service delivery system. The Early Learning Council, created in 2003 by Public Act 93-0380, coordinates existing programs and services for children from birth to five years of age in order to meet the early learning needs of children and their families. The Council is comprised of gubernatorial and legislative appointees representing a broad range of constituencies and the MCH program is represented on four of five committees.

The Council chose to develop a comprehensive plan for Preschool For All based on: The Governor's commitment to voluntary access to high-quality early education services for all young children whose parents chose to participate; Past planning efforts; and The Council's commitment to ensuring that all Illinois children are safe, healthy, eager to learn and ready to succeed by the time they enter school.

The Governor has acted on the recommendations of the Early Learning Council to move toward preschool access for all three and four year olds whose parents want them to participate. The Governor's FY2007 budget proposal included an additional \$45 million for the Early Childhood Block Grant in each of the next three years as the first part of a five-year Preschool For All plan. The General Assembly appropriated the amount of money the Governor requested. The Preschool For All plan addresses several interrelated goals of the Council, including: Enhancing the quality of early learning programs for children birth to three and three to five that include quality assurance and evaluation; Expanding access to and the quality of early learning programs; Linking programs to others serving families with young children; and Developing the early childhood workforce to ensure an adequate, stable supply of highly-qualified and diverse individuals to staff early learning programs.

The Illinois Children's Mental Health Partnership envisions a comprehensive, coordinated children's mental health system comprised of prevention, early intervention, and treatment services for children ages 0-18 years and for youth ages 19-21 who are transitioning out of key public programs. The "Strategic Plan for Building a Comprehensive Children's Mental Health System in Illinois" was submitted to the Governor on June 30, 2005. The MCH program is represented on the Early Childhood Committee of the Partnership and its work groups. The work of the Committee focuses on: An early childhood mental health consultation initiative, The adoption of diagnostic codes for very young children, Increasing the response to maternal perinatal depression, Establishing social emotional and developmental screening and assessment, Expanding and developing the early childhood mental health workforce, and Ensuring that parents are equal partners in the emerging children's mental health system.

/2008/ A large public awareness campaign was initiated with the release of a \$500,000 request for proposals to raise awareness that persons with mental illness can and do recover and that treatments are available and successful. Ten proposals were submitted and evaluated in early 2007. The partnership intends to begin the campaign during the SFY2008. //2008//

/2009/ To promote good mental health for everyone in Illinois, a public awareness campaign--Say It Out Loud-- was launched in May 2008. This campaign was initiated with the release of a \$500,000 request for proposals to raise awareness that persons with mental illness can and do recover and that treatments are available and successful. . The Say It Out Loud campaign uses radio spots, ads in newspapers statewide, billboards, t-shirts, brochures, palm cards, presentations and a website www.mentalhealthillinois.org. //2009//

The IDHS Bureau of Child Care and Development's Early Childhood Mental Health Consultant Pilot expanded from four to nine sites in FY2006. Each Mental Health Consultant works with childcare providers and the Child Care Resource and Referral Agency staff to provide program-level consultation and technical assistance, training, and community level support. The IDHS Bureau of Early Intervention utilizes mental health consultants and implemented a social emotional screening component at every Child and Family Connection Agency in Illinois. The

Partnership received a grant from the Michael Reese Trust for a mental health consultation pilot to expand the capacity of community mental health agencies in Chicago to provide treatment services for children birth to seven years old. The partnership hosted an Early Childhood Mental Health Consultant Retreat and established a statewide early childhood mental health consultant network. A work group of the Early Childhood Committee is working toward the adoption of a Diagnostic Code: 0-3 R Crosswalk and will develop the training necessary for implementation. The Early Childhood Mental Health State Plan Work Group has written a charter to define the goals and outline the work of the group. This charter was adopted by the Directors of IDHS' Divisions of Mental Health and Community Health and Prevention. A work plan will be developed and activities initiated during FY2006.

//2008/ In FY'07 the Early Childhood Mental Health consultant pilot expanded to 13 sites. //2008//

//2009/ The IDHS Bureau of Child Care and Development's Early Childhood Mental Health Consultant Pilot is now a permanent part of the support services offered to families and providers in Illinois. Named "Caregiver Connections", the program will provide services throughout the state by the end of FY08. Each Mental Health Consultant works with childcare providers and the Child Care Resource and Referral Agency staff to provide program level consultation and technical assistance, training, and community level support.

Primary Care Psychiatric Consultation Line: The IDHFS and IDHS partnered with the Illinois Children's Mental Health Partnership to develop a model for a psychiatric phone consultation initiative for primary care providers. This psychiatric phone consultation model will provide: a statewide mental health and substance abuse consultation phone line, staffed by university based psychiatric experts, for primary care providers who treat children and adolescents; consultation on a variety of topics, including but not limited to assessment, treatment options, medication management and local community supports for publicly funded children experiencing mental health challenges; and the development of procedures and protocols for standard pediatric psychiatric conditions, including medication management. //2009//

There is a growing medical malpractice insurance crisis in Illinois. In response, the Illinois' General Assembly passed Senate Bill 0475, which limits awards for non-economic damages to \$500,000 against a physician and \$1 million against a hospital. The Illinois Department of Insurance will be required under certain circumstances to hold hearings regarding increases in medical malpractice insurance premiums. The bill was enacted in August 2005.

Allocation of Resources. The IDHS allocates its resources by "Giving highest priority to those areas in Illinois having high concentrations of low-income families, medically underserved areas, and those areas with high infant mortality and teenage pregnancies . . ." (77 Ill. Adm. Code 630.20 (a)(2)). Allocation decisions are made on the basis of competitive proposals, per capita allocations, or by other means. By federal law, IDHS allocates 30 percent to DSCC for CSHCN.

B. Agency Capacity

Agency Capacity

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children (including those with special health care needs), adolescents, and women of reproductive age through a coordinated system of services. This system is supported primarily by the programs of the Division of Community Health and Prevention in IDHS, the Office of Health Promotion and the Office of Health Protection at IDPH, and the UIC Division of Specialized Care for Children (DSCC).

Statutory Base. The IDHS Division of Community Health and Prevention is responsible for administration of the Maternal and Child Health Block Grant, as well as the following state

statutes: The Hearing Screening for Newborns Act requires hospitals to screen newborns for hearing loss. The Illinois Family Case Management Act gives IDHS statutory authority to operate the Family Case Management program and establishes the Maternal and Child Health Advisory Committee. This law replaced the Infant Mortality Reduction Act. The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral. The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral. The Prenatal and Newborn Care Act authorizes payment for prenatal care, delivery, postpartum care, and "two EPSDT-equivalent screenings" of the newborn.

The Illinois Department of Public Health is responsible for the administration of the following state statutes: The Developmental Disability Prevention Act authorizes regional perinatal health care in Illinois. The Phenylketonuria Testing Act authorizes newborn screening for phenylketonuria, hypothyroidism, galactosemia, "and other metabolic diseases as the Department may deem necessary." The Counties Code provides for the autopsy of children under age two years and reporting of deaths suspected to be due to Sudden Infant Death Syndrome (SIDS) by the county coroner. The Illinois Lead Poisoning Prevention Act is comprehensive legislation regarding the use of lead in consumer products and dwellings. The law requires screening of children through age six; reporting results; the inspection and abatement of environmental lead hazards; and maintaining and providing educational materials. The Suicide Prevention, Education, and Treatment Act authorized IDPH to carry out the Illinois Suicide Prevention Strategic Plan. When funds are appropriated, IDPH is to develop five pilot programs that provide training and direct service programs to communities.

/2008/ The Suicide Prevention, Education, and Treatment Act authorized IDPH to carry out the Illinois Suicide Prevention Strategic Plan. It directs IDPH to appoint an advisory board to oversee the development and implementation of the Illinois Suicide Prevention Strategic Plan. In addition to the strategic plan, it also is charged with implementing: 1) a statewide suicide prevention conference; 2) a media campaign; 3) a public awareness campaign; 4) education initiatives; and 5) when funds are appropriated, develop five pilot programs to provide training and direct service programs to communities. //2008//

The Reduction of Racial and Ethnic Disparities Act provides grants to individuals, local governments, faith-based organizations, health care providers, social service providers and others to "improve the health outcomes of racial and ethnic populations." This bill was enacted in August 2005.

In 1957, The Specialized Care for Children Act designated the University of Illinois as the agency to administer funds from "the United States Children's Bureau of the Department of Health, Education and Welfare" to support "a program of services for children who are crippled or suffering from conditions which may lead to crippling, including medical, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization, and aftercare for such children."

Overview of Programs and Services. Illinois' Title V program focuses on three main areas: the reduction of infant mortality; the improvement of child health (including the health of children with special health care needs); and the prevention of teen pregnancy. Within these broad priorities are seven groups of programs: preconceptional; pregnancy; infancy and early childhood; middle childhood; adolescence; children with special health care needs; adults; and infrastructure development. Each group of programs is discussed below: Preconceptional. The Family Planning program and IDHFS' Illinois Healthy Women program are the state's primary strategies for improving preconceptional health. This program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted diseases.

Services are available statewide through a network of delegate agencies. A new protocol for preconceptional education was implemented this year. Further, Family Case Management program grantees can use a limited amount of their grant funds to provide family planning services for the medically indigent when there is no delegate agency nearby. All family planning services are provided in accordance with federal regulations for the Title X program. The Family Planning program is also supporting two male responsibility demonstration programs in Chicago.

/2008/ On June 20, 2007, IDHS sponsored a statewide satellite production that introduced a protocol for preconceptional education to Family Planning providers. Approximately 200 service providers attended this satellite training. Requests for copies of the production topped 300 and more requests continue to be satisfied. //2008//

/2009/ A statewide Pre/Interconceptional Care Committee was formed in FY'07, with the goal of developing and implementing a 3-5 year strategic plan. Membership consists of representatives from IDHS, IDHFS, IDPH, local Health Departments, Delegate Family Planning programs, March of Dimes, Illinois Maternal and Child Health Coalition and others. To date, a grid outlining recommended components of pre/interconceptional care has been developed, an Education and Outreach sub-committee has been formed, and a Social Marketing strategy is being defined. //2009//

/2009/ A satellite training on Motivational Interviewing is planned for June 17th, 2008. The purpose of the training is to instruct providers in techniques to conduct interviews in a manner that promotes self-care and self-management around various health issues, including pre/interconceptional care. //2009//

/2009/An Interconceptional Care Pilot project, Healthy Births for Healthy Communities, continues on the westside of Chicago. The model is intended to improve birth outcomes in the pilot communities and targets women who have experienced a recent fetal or neonatal loss, or had a premature or low birth weight infant. To date, 83 women have enrolled. They are followed by a nurse care manager and a community case manager who are in close regular and ongoing consultation with the participant's health care provider. Intervention lasts for 18 months and includes education related to reproductive health and linking with identified needed services, based on a variety of assessments. These women select a minimum of one self-care goal. In the past 18 months, only two women in the program have become pregnant.//2009//

/2010/ To date, 239 women have enrolled and six women in the program have become pregnant.//2010//

/2009/ IDHFS, in partnership with IDHS launched a pilot to test a preconception care risk assessment tool in FY'08. This initiative allows IDHFS to develop, test, evaluate and validate a risk screening tool for preconception care. Once the tool has been tested, evaluated and validated, IDHFS intends to provide reimbursement for preconception risk screening, if found effective.//2009//

/2009/ Initial reports indicate that only 50 percent of postpartum women have a contraceptive method identified in their Cornerstone record, and a fraction have a documented referral to a family planning provider. In FY'09, FCM providers will be monitored for documentation of a family planning and the Integrated Plan for FCM and WIC services will include an objective related to referral of clients to a family planning provider. //2009//

Three other strategies are used to improve preconceptional health. The IDPH supports a statewide genetic counseling program through grants to medical centers for diagnostic, counseling and treatment services; through grants to local health departments for genetic case-finding and referral; and through grants to pediatric hematologists at medical centers that offer diagnosis, treatment, counseling and other follow-up services. The Title V program also works with the Illinois Chapter of the March of Dimes to conduct a statewide campaign promoting the

consumption of folic acid. Finally, the Nutrition Services Section in the Division of Community Health and Prevention leads the state's Five A Day for Better Health initiative.

//2008/ The Five A Day program changed to the Fruits and Veggies - More Matters program in 2007. //2008//

Prenatal. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the Chicago Department of Public Health and, on a limited basis, through the Family Case Management program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Family Case Management (FCM). The WIC program provides nutrition education and supplemental foods to pregnant or lactating women and children under the age of five from low-income families. FCM provides service coordination to low-income families with a pregnant woman or an infant.

The Title V program includes several targeted enabling service initiatives for pregnant women in particular areas or with particular health conditions. First, Targeted, Intensive Prenatal Case Management projects are placed in communities with high Medicaid expenditures during the first year of life and seek to prevent low birth weight. The number of agencies expanded in SFY'06 from 10 to 13. IDHS, IDHFS and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which will provide performance incentives for outreach to high-risk pregnant women in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Department also operates a federally-funded Closing the Gap project targeted to four Chicago Community Areas with high African-American infant mortality rates. The latter two projects are supported with grants from the Maternal and Child Health Bureau. IDHS continues to work with the AIDS Activity Section within IDPH to train prenatal care providers on strategies to prevent perinatal transmission of the HIV. Legislation has been passed to allow for the implementation of rapid HIV/AIDS testing of pregnant women.

//2009/ Results of an evaluation of Closing the Gap suggested that ensuring access to prenatal care is not sufficient if that care is not responsive to a woman's unique needs and does not meet the recommended standards of care suggested by professional organizations and public health professionals. Not considering risk status, the study provided evidence that the quality/content of prenatal care provided to low-income women on Medicaid in four Chicago community areas did differ somewhat by care provider. When just examining the unadjusted relationship between provider type and content/quality of care it appeared that the majority of women receiving care from physicians were receiving content in the middle of the distribution (50-79%); compared to FQHCs, physicians were twice as likely to provide medium quality care as opposed to the highest quality care. //2009//

//2009/ In FY'08, FCM services were reinstated at the Cermak Women's Unit at the Cook County jail, for women who are pregnant at time they are arrested and incarcerated. Women are primarily African American and Hispanic, the majority of whom are less than 30 years of age. Two case managers are housed inside the jail and complete an assessment of client needs. Prior to discharge, the case managers assist the woman in access housing and intervention programs, as well as prenatal care services. An external Case Manager works with each woman upon discharge to assure she accesses community programs and stays connected with prenatal care. Approximately 50 new inmates a month are enrolled in the program. //2009//

Finally, at the population level, IDPH administers the state's regionalized perinatal care system. Four levels (capabilities) of perinatal care are well-defined in administrative rules: basic or Level I, intermediate or Level II, specialty or Level II+ with extended capabilities, and sub-specialty or Level III, with all facilities integrated into networks of care. Program activities focus on improving

the quality of perinatal care and increasing the proportion of very low birth weight infants who are born in Level II+ or Level III centers.

Infants and Young Children. The Title V program includes direct service, enabling, population-based and infrastructure building initiatives for infants and young children. These services begin with two newborn screening programs. The state has supported a metabolic screening program for many years. The IDPH Newborn Screening Laboratory performs centralized testing on all samples and results are reported to IDPH Newborn Screening follow-up program staff. Infants with positive results for a genetic or metabolic disorder are followed through case closure or through diagnosis and initiation of treatment, and annually through 15 years of age. DSCC supports diagnostic evaluations necessary to establish a potentially DSCC eligible diagnosis. DSCC also provided care coordination for those children with eligible conditions, and financial assistance for specialty medical care if financial eligibility criteria are met. For young children who are deaf or hard of hearing, DSCC co-sponsors the Institute for Parents of Preschool Children who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf and the Illinois State Board of Education. On July 1, 2002, the newborn screening program added tandem mass spectrometry testing of all newborns for amino acids, organic, and fatty acid oxidation disorders. The Newborn Hearing Screening Program is jointly administered by IDHS, IDPH and DSCC. Hospitals report all hearing screening results to IDPH. The child's parents and physician are notified of the test results and provided with an informational brochure with guidance for follow-up testing. DSCC pays for diagnostic testing if the family does not have insurance coverage or financial assistance through the program for this service. Infants are referred as indicated to the CSHCN program and the Part C Early Intervention program.

/2008/ In July 2007, screening for cystic fibrosis will be added to the screening panel. In addition, screening for Lysosomal Storage Disorders is being considered in the next several years. //2008//

/2009/ The Governor signed Public Act 95-0695 in November 2007, which will require the addition of screening tests for five lysosomal storage disorders, within the next three years. //2009//

/2010/ In March 2008, screening for cystic fibrosis was added to the screening panel. In addition, a pilot testing period screening for Lysosomal Storage Disorders will begin in November 2010, with statewide screening beginning in June 2011.//2010//

The Title V program includes six statewide programs for infants and young children. The FCM program serves low-income families with infants and also serves a limited number of children who are under five years of age and are at risk for health or developmental problems. FCM grantees can use a limited amount of their grant funds to pay for primary pediatric care for medically indigent children. The WIC program also serves low-income children who are under five years of age and have a nutritional risk factor. The Early Intervention Program (authorized under Part C of the Individuals with Disabilities Education Act) provides coordinated, comprehensive, multidisciplinary services to enhance the growth and development of children from birth through 36 months of age who have developmental disabilities and delays. Services include case coordination, developmental therapy (special instruction), physical therapy, occupational therapy, speech therapy, assistive technology, nursing services, nutrition services, vision services, audiologic services and medical diagnostic services for purposes of eligibility determination. The EI program has added a social-emotional consultant in each of the 25 community-based agencies that provide intake and coordinate services for eligible families. The IDPH Childhood Lead Poisoning Prevention Program directs the screening of children six months through six years of age for lead poisoning, collects all blood lead test results, and provides medical case management. The IDPH Immunization Program distributes vaccine, conducts surveillance, investigates disease outbreaks, conducts educational programs, assesses vaccine coverage levels, conducts quality assurance reviews among 2,800 healthcare providers enrolled in the Vaccines for Children Program, and promulgates regulations related to vaccination. Finally, the Title V program and the Child Care program in IDHS jointly support a statewide network of Child

Care Nurse Consultants who train and consult with child care providers.

The Title V program includes or works closely with several initiatives for infants and young children with particular needs or risk factors. The High-Risk Infant Follow-up Program, a component of FCM, serves infants who have a high-risk medical condition identified through the IDPH APORS program. These infants, as well as families who experience a perinatal death, are referred to local health departments for follow-up visits by registered nurses, and follow-up may continue until the child's second birthday. The Healthy Families Illinois Program seeks to prevent child abuse and neglect through intensive home visits that provide parenting skills education to high-risk families. The HealthWorks of Illinois (HWIL) Program, another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (DCFS) to ensure that wards of the state receive comprehensive, quality health care. The IDPH Early Childhood Caries (ECC) program integrates oral health into every WIC and Head Start program in Illinois. The goal of the Child Safety Seat program is a reduction in automobile-related injuries and fatalities among children under the age of four. The program makes a limited number of car seats available at no charge to low-income families. Families are given hands-on instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. The Sudden Infant Death Syndrome (SIDS) Program serves families who have experienced a sudden, unexpected infant death. Counseling and support services are offered to all families by a local public health nurse who has received training as a bereavement counselor.

//2009/ IDPH also provides funding to the not-for-profit organization, Sudden Infant Death Services of Illinois, to provide bereavement services for families and risk reduction education for health care providers and consumers. //2009//

The Title V program includes four infrastructure development projects that affect young children. The Fetal and Infant Mortality Review (FIMR) project reviews fetal and neonatal deaths in Chicago to identify social risk factors and recommend preventive interventions. The Title V program and many providers and child advocates work with the Ounce of Prevention Fund on the Birth to Five Project to develop a comprehensive, coordinated, easily-accessible system of high-quality preventive services for children before birth and through five years of age. In 2002 Illinois was selected as one of four states to receive funding from the Early Childhood Funders' Collaborative for the Build Initiative. Ten All Our Kids (AOK) Early Childhood Networks were established by the Birth to Five Project to improve local systems of care for families with young children. Two additional sites initiated networks in FY2006 with Early Childhood Block Grant Funding from the Illinois State Board of Education. The Assuring Better Child Health and Development (ABCD II) Project, called Healthy Beginnings, is sponsored by the Commonwealth Fund and funded by the Michael Reese Health Trust. The purpose of Healthy Beginnings is to strengthen primary care services and systems that support young children's healthy mental development.

//2008/ The "Enhancing Developmentally Oriented Primary Care" project began in 2007 to identify and overcome the barriers that pediatric primary care providers face in conducting developmental, social-emotional, postpartum depression, and domestic violence screenings, making appropriate referrals and attending to parents' developmental concerns. The EDOPC project helps Illinois' pediatric care providers through training, technical assistance and community support, implementing strategies to effectively provide developmentally oriented primary care. //2008//

Middle Childhood. The Title V program includes several programs for children in middle childhood. The Vision and Hearing Screening Program administered by IDPH supports screening activities by local health departments, school districts or other contractors to identify children with possible problems. IDPH also coordinates ophthalmologic, optometric, otologic, and audiologic examination clinics throughout the state. The Dental Sealant Grant Program (DSGP) works with interested communities to establish school-based programs for dental sealant applications, oral

health education, outreach for All Kids enrollment, dental examinations and referral for dental treatment needs. Coordinated School Health Program grants are provided to 12 local health departments and school districts to promote implementation of a Coordinated School Health Program model to address the health needs of students in grades K-12. The School Health program provides comprehensive consultation and technical assistance to schools throughout the state. Professional continuing education programs (School Health Days and Critical Issues Conferences) for qualified school and public health nurses, social workers, health educators, and school administrators are conducted annually. Forty School Health Centers provide health care services to students enrolled in elementary and middle schools. In collaboration with the IDPH Division of Oral Health, centers are serving as pilot sites to implement an oral health education curriculum into grades K-12. Two childhood asthma demonstration projects in Chicago use peer or community health educators to empower communities to deal with this complex health issue.

//2008/ Forty-one School Health Centers provide health care services to students enrolled in elementary and middle schools. //2008//

Adolescents. The Title V programs for adolescents include direct health care services through School Health Centers; projects to prevent teen pregnancy; transition services for CYSHCN, family support programs for pregnant and parenting teens; youth development and juvenile justice programs. The School Health Centers promote healthy lifestyles through health education and comprehensive direct physical, dental, and mental health services. Services are provided within or nearby the schools by licensed professional staff or through referral to other local health care providers. Health centers that meet established standards are enrolled as Medicaid providers. The School Health Centers engage in Continuous Quality Improvement (CQI) activities related to health risk assessment of students. The professional staff currently assesses each patient for overweight and other health problems. Health center staff then identify and implement health education, health promotion and interventions in these areas.

The Primary Teen Pregnancy Prevention Program provides support for community-based planning to reduce teen pregnancy, sexually transmitted infections and the transmission of HIV. This is done through a combination of education, service delivery and referrals appropriate to the age, culture and level of sexual experience of youth by providing services in either classroom or community settings. The Primary Teen Pregnancy Prevention program providers focus their efforts on three of the five program components: sexuality education, family planning information and referrals, youth development, parental involvement, male involvement or public awareness.

Title V also includes four programs for teen parents. The Teen Parent Services (TPS) program is mandated for young parents (under age 21) who are receiving or applying for TANF and who do not have a high school diploma or its equivalent upon entry into the program. It is offered to young parents who receive Medicaid, WIC, FCM, or Food Stamps. TPS helps these young parents enroll and stay in school, and results in a young parent who is better prepared to make the transition from TANF or other public benefits to economic self-sufficiency. The program also assists any pregnant/parenting teen to access other IDHS programs and benefits. The Parents Too Soon (PTS) program helps new and expectant teen parents to develop nurturing relationships with their children, reduce the rate of subsequent pregnancy, improve their own health and emotional development, and promote the healthy growth and development of their children. Services include weekly home visits and monthly peer group meetings. The Responsible Parenting program assists adolescent mothers who are between 13 and 18 years of age to delay subsequent pregnancies, consistently and effectively practice birth control, continue their schooling to high school graduation, develop parenting skills and to cope with the social and emotional problems related to pregnancy and parenting. Finally, a Doula, or birthing assistant, is a woman who provides emotional support to a woman throughout the antepartum and postpartum periods. Five program sites provide Doula services beginning in the third trimester of pregnancy and continuing through the first three months following birth.

There are four youth development programs in the Division of Community Health and Prevention.

The Youth Opportunity Program focuses on children who are TANF-eligible or other low-income families to help them break the generational cycle of welfare dependency and help prevent school dropout, unwanted pregnancies, and gang involvement. Students receive career development training and individual, group and family counseling. The Bureau of Youth Services and Delinquency Prevention offers community-based out-of-school time programming, as well as a comprehensive array of prevention, diversion, intervention, and treatment services targeting youth to stabilize families in crisis, prevent juvenile delinquency, and divert youth at risk of involvement in the child welfare, juvenile justice, or correctional systems. The Bureau of Community-Based and Primary Prevention funds community-based prevention initiatives and prevention training and education for youth in the areas of abstinence education, substance abuse prevention and volunteerism and community service. The Bureau's programming fosters the development of positive lifestyles and the reduction of substance abuse in Illinois through outcome/evidenced based planning and programming.

/2008/ There are now five youth development programs in the Division of community Health and Prevention. //2008//

/2008/ There also is the GEAR UP (Illinois Steps AHEAD) program, which is a discretionary grant program implemented to augment the number of low-income students who are academically prepared and ready to succeed in post secondary education. These services include college visits, tutoring, career exploration, and job shadowing. Students are accepted no earlier than seventh grade, and their progress is monitored throughout high school. //2008//

Children with Special Health Care Needs. The Title V program for children with special health care needs (CSHCN) is operated by the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC). It serves approximately 23,000 children annually through the Core Program, the IDHFS Home Care Waiver Program, the SSI Disabled Children Program, and the Children's Habilitation Clinic.

The goal of DSCC's Core Program is to assure community based, family centered, and culturally sensitive provision of comprehensive care coordination services for eligible CSHCN and their families. Core Program services include comprehensive evaluation, specialty medical care, care coordination, and related habilitative services appropriate to the child's needs and financial support for those families who are financially eligible. The program serves children with impairments associated with the following categories: orthopedic, nervous system, cardiovascular, craniofacial deformities, hearing, organic speech, eye and urinary system and cystic fibrosis, hemophilia and inborn errors of metabolism.

Initial diagnostic evaluation services are provided in part by a network of more than 70 field clinics, consisting primarily of orthopedic clinics, administered and funded by DSCC, as well as through office visits with private physicians and other freestanding clinics. The clinic system allows medical specialists and professional staff to provide diagnostic evaluation and treatment of children with medical conditions eligible for DSCC services, assisting children to access specialists not available in their communities.

/2009/ DSCC administered and funded 56 field clinics. //2009//

/2010// DSCC administered and funded 58 field clinics. //2010//

DSCC has a network of 13 regional offices with care coordinators (nurses, social workers, and speech pathologists/audiologists) that develop an Individual Service Plan (ISP) for each child following the initial evaluation process to specify the care coordination services needed and the financial support required for treatment. The ISP reflects the child's and family's perceived needs, the medical needs as articulated by the managing physician, the appropriate service providers to meet those needs and all available sources of funding to address those needs.

/2008/ With the parents' permission, the ISP is shared with the child's Medical Home provider and all other specialists and therapists when appropriate. //2008//

Children with a potentially eligible condition receive diagnostic and care coordination services without regard to a financial eligibility. Families of those children requiring financial support for treatment services must demonstrate a total income below 285 percent of the federal poverty level adjusted for family size. All families must maximize existing health insurance benefits before financial assistance can be provided. Families of uninsured CSHCN who meet All Kids financial requirements are required to apply and enroll (if eligible) in All Kids in order to continue to receive financial assistance from DSCC. Children with All Kids coverage receive care coordination to assist them in accessing services and limited financial assistance for services not covered by All Kids.

DSCC employs eight bilingual staff members and has correspondence in Spanish available, including the Special Addition newsletter. Families whose primary language is not English or Spanish have use of the AT&T Language Line as a resource. In addition, the Family Advisory Council (FAC) promotes cultural diversity in its membership.

/2008/ DSCC currently employs 12 bilingual staff members to assist those families with limited English proficiency who speak Spanish. //2008//

/2009/ DSCC employed two additional bilingual staff members in the Chicago Administrative Office. These staff members provide limited English proficiency technical assistance to support care coordination staff throughout the state and promote quality in translated material.//2009//

DSCC operates the Title XIX Waiver for Home and Community-Based Services for Medically Fragile/Technology Dependent Children, which is administered through the IDHFS. The program provides cost-effective care coordination and supportive home services to children with complex medical needs who would otherwise be at risk of prolonged institutionalization or re-institutionalization in a hospital or long-term care facility. Beginning with FFY'05, the costs of skilled nursing services associated with this program have been excluded from the budget and expenditure reports in Forms 2, 3, 4 and 5.

DSCC is the agency designated to administer the Supplemental Security Income-Disabled Children's Program (SSI-DCP). Children are determined to be eligible for this program through the Illinois Disability Determination Services (IDDS), which, in turn, refers SSI medically eligible children to DSCC for further assistance. DSCC receives information on approximately 275 SSI-eligible children a month who are under 16 years of age.

/2008/ Currently, approximately 150 SSI-eligible children a month who are under 16 years of age are referred to DSCC. //2008//

/2009/ Approximately 170 SSI-eligible children a month who are under 16 years of age are referred to DSCC.//2009//

/2010// Approximately 218 SSI eligible children who are under 16 years of age were referred to DSCC for potential enrollment based upon the child's medical condition Efforts to reach families of children newly eligible for SSI by telephone will be expanded to include all ages of children referred to DSCC by the Division of Disabilities Determination.//2010//

DSCC provides information and referral services to these SSI-eligible children by sending comprehensive profiles on state/local programs, including the DSCC Core Program, which may benefit the child or family. Families may request information in Spanish. Additionally, a toll-free 800 number is provided to all families to access further information and additional assistance. An application is sent to families with a child who may be eligible for DSCC services and the

appropriate Regional Office provides referral follow-up. Through telephone contact or provision of program information, DSCC staff links those children under the age of five years to Part C Early Intervention, Part B Early Childhood, and Pre-Kindergarten for Children at Risk as appropriate. DSCC telephones families with children ages three to four to offer assistance in linking to appropriate resources.

/2009/ SSI-eligible children ages 14-16 years old also receive a telephone call to offer assistance in linking to appropriate resources, including transition planning resources.//2009//

The Children's Habilitation Clinic is located within the Children and Adolescent Center of the Outpatient Care Center, the University of Illinois at Chicago's comprehensive outpatient facility. This location allows clinic staff to collaborate with other sub specialists and with primary care physicians and nurse practitioners. Staff provides comprehensive diagnostic services for children with complex disabling conditions and developmental management to those children through age 21. For all second-year pediatric and medical residents at UIC's School of Medicine, and other health care students, the clinic also provides a required rotation in the care of children with disabilities. There are approximately 1,600 patient visits annually.

DSCC cosponsors the Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf, and the Illinois State Board of Education. This is a weeklong educational program for parents of children, ages birth to five, who have a significant hearing loss. The Institute provides an opportunity for parents to learn about deafness and their child's individual strengths and needs, as well as meet other parents who have children with hearing loss. The Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing also provides multidisciplinary evaluations. At the conclusion of the Institute, parents meet with staff to discuss evaluation results and treatment recommendations and to plan for the future.

DSCC is collaborating with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Illinois Academy of Family Physicians, and the Shriner's Hospitals for Children to identify and train Primary Care Physicians (PCP) to serve as the Medical Home Providers for CSHCN who participate in the Title V program. In order to be enrolled in DSCC, Medical Home Providers are required to complete a Continuing Medical Education (CME) Monograph on Medical Home (within six months of application), in addition to being board certified as a pediatrician or family physician and meeting the other DSCC general provider criteria. PCPs who complete training (and meet DSCC's general criteria) are able to bill for care coordination activities, follow-up on medically eligible conditions as agreed upon by the specialist, and telephone consultation, if needed with a pediatric specialist. DSCC care coordinators assist in facilitating communication and reports among the providers involved with the individual child.

DSCC is represented on the Illinois Interagency Council on Early Intervention (IICEI). Care coordination is provided for families with children jointly enrolled in DSCC and Early intervention (EI) program. Financial assistance is provided for specified medical services for families who are financially eligible (i.e., surgery, medications, durable medical equipment and supplies).

As a member of the Illinois Interagency Coordinating Council on Transition, DSCC is collaborating to develop a statewide plan to improve access to and availability of comprehensive transition services. Council members sponsor an annual statewide conference. Other members of the Council represent state agencies in the following areas: education, corrections, employment/training, health, and human services.

DSCC, in collaboration with MCHB's Division of CSHCN, has developed and published a newsletter, *Special Addition*, containing articles of national and state interest. Illinois continues to coordinate the family newsletter template with more than 30 other states. *Special Addition* is available to families in both English and Spanish. /2009/ This collaboration ended this year. //2009//

/2010/DSCC continues to publish Special Addition for enrolled DSCC families with a focus on state and local topics of interest to families of children with special health care needs. The newsletter is available to the general public on the DSCC website. Adults. The Title V program supports or collaborates with several programs for adults. Parents Care and Share of Illinois conducts support groups across the state for parents. The Bureau of Domestic and Sexual Violence Prevention administers domestic violence and sexual abuse prevention programs throughout the state, offering comprehensive, community-based services that meet the immediate and long-term needs of victims and their children. //2010//

Adults. The Title V program supports or collaborates with several programs for adults. The Illinois Fatherhood Initiative conducts several activities to promote fathers' active participation in their children's lives. Parents Care and Share of Illinois conducts support groups across the state for parents. The Bureau of Domestic and Sexual Violence Prevention administers domestic violence and sexual abuse prevention programs throughout the state, offering comprehensive, community-based services that meet the immediate and long-term needs of victims and their children.

Infrastructure Building. Finally, the Title V program includes several infrastructure-building initiatives. The Chicago MCH Mini-Block Grant to the Chicago Department of Public Health supports direct and enabling services to pregnant women, children and women of reproductive age. The Department works with the UIC School of Public Health to conduct several leadership development program for state and local Title V program staff.

C. Organizational Structure

Organizational Structure

As described in previous MCH Services Block Grant Applications, the Governor has designated the IDHS as the state health agency responsible for the administration of the MCH Services Block Grant. Through an interagency agreement, MCH Services Block Grant funds are transferred to the IDPH for the administration of the Vision and Hearing Screening, Oral Health, Genetics, Childhood Lead Poisoning Prevention and Perinatal Care programs. In compliance with federal law, IDHS transfers 30 percent of Illinois' MCH Services Block Grant funds to DSCC for services to CSHCN. Copies of current interagency agreements are on file in the Division of Community Health and Prevention. Additional information about the structure of these three agencies is presented below.

The Illinois Department of Human Services. The IDHS is organized into six divisions. The Division of Community Health and Prevention (DCH&P) includes the family planning, infant mortality reduction, early childhood services (Early Intervention) and system development, school health, teen pregnancy prevention, teen family support, child abuse prevention, substance abuse prevention, domestic violence prevention and intervention, sexual assault prevention and response, youth services, and delinquency prevention programs. The Division of Developmental Disabilities includes the Supplemental Security Income Disability Determination Service, as well as programs for persons with developmental disabilities. The Division of Human Capital Development includes adult employment, income assistance, food and shelter, refugee services, child care, and special social service projects and is responsible for the Department's local offices. One or more local offices are located in almost every county of the state. Staffs in these offices perform intake and eligibility determination for cash assistance, Food Stamps, Medicaid, SCHIP, and other programs. The Division of Alcoholism and Substance Abuse is responsible for substance abuse treatment services. The Division of Mental Health is responsible for the state's system of community-based mental health care as well as psychiatric hospitals. The Division of Rehabilitation Services oversees the state's system of care for persons (mostly adults) who are physically challenged.

The Department has redefined the scope of its Maternal and Child Health program to include all

of the programs within the Division of Community Health and Prevention that target women, infants, children and adolescents. The Division has implemented an interim organizational structure. The Director of Community Health and Prevention will now serve as Illinois' Title V Director. Responsibility for operational supervision of the eight program bureaus and the regional Community Support Services Consultants has been placed in an Associate Director for Community Support. The former Offices of Family Health and Prevention have been dissolved. The two Associate Directors advise the staff of all Division programs regarding policy and represent the Division to advocacy and provider groups, legislators, task forces, boards and other groups that affect the Division's services. The Division has established an Office of Program Planning and Development to support performance management, program evaluation, grant writing and new program implementation.

/2009/ A new organizational structure was adopted by the division in June 2008. There are five functional areas: Reproductive and Early Childhood Services, Youth and Adult Services, Community Support Services, Program Planning and Development, and Fiscal Services. //2009//

The Division's bureaus and regional consultants have established a statewide network of comprehensive, community-based systems of health and social services for women of reproductive age, infants, children and adolescents to assure family-centered, culturally competent and coordinated services. The Bureau of Maternal and Infant Health is responsible for the Family Planning, Family Case Management, Chicago Healthy Start, Targeted Intensive Prenatal Case Management, Closing the Gap, Early Childhood Comprehensive System Development (including the AOK Networks and the Healthy Child Care Illinois project), HealthWorks, Pediatric Primary Care, High-Risk Infant Follow-up, the Chicago Doula Project, Healthy Births for Healthy Communities, and Fetal and Infant Mortality Review programs, as well as the "Mini Block Grant" to the Chicago Department of Public Health. The Bureau of Child and Adolescent Health is responsible for the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, School Health, Teen Pregnancy Prevention, and Responsible Parenting programs. The School Health program includes the Coordinated School Health program, School Health Centers and continuing education programs for school health personnel. The Bureau of Family Nutrition is responsible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Commodity Supplemental Foods Program, 5-A-Day for Better Health, Folic Acid, the Diabetes Prevention and Control Program (funded with a grant from CDC), and WIC and Senior Farmers' Market Nutrition Program.

The Office of Program Planning and Development oversees the leadership development programs supported by the State Systems Development Initiative.

The MCH program is supported by five other units: the Nutrition Services Section in the Bureau of Family Nutrition; the Bureau of Community Health Nursing; the Bureau of Performance Management Services in the Office of Program Planning and Development, the Bureau of Community Support Services, and the Bureau of Fiscal Support Services. The role of each of these units is described below.

The Nutrition Services Section in the Bureau of Family Nutrition is comprised of regional nutrition consultants, a state breastfeeding coordinator, and a state nutrition coordinator. All are masters-prepared Registered Dietitians with expertise in maternal and child health. The section provides consultation and technical assistance on nutrition issues for the WIC and other maternal and child health programs.

The staff of the Bureau of Community Health Nursing (BCHN) work to ensure that the services provided by MCH program grantees are of high quality. The BCHN is composed of masters-prepared Maternal and Child Health Nurse Consultants who are geographically distributed throughout the state. The MCH Nurse Consultants develop and present in-service training, continuing education programs, and technical assistance for local agency staff. The BCHN is also responsible for the Asthma Education Program.

The Bureau of Performance Support Services (PSS) performs a variety of activities related to the collection, maintenance, and evaluation of community health and prevention data, and the development and presentation of training sessions to enhance the skills of prevention service providers.

The Bureau of Community Support Services performs contract monitoring and helps local program grantees integrate their services in order to respond effectively to community needs.

The Division of Community Health and Prevention's Bureau of Fiscal Support Services accounts for the Division's financial resources.

Information and Referral Helpline. MCH Helpline staff answer three 800 lines: 1) 800-323-GROW/4769; 2) 800-545-2200 (MCH); and 3) 800-843-6154, option #5 (DHS Customer Service Line). The staff of four field about 4,000 calls per month, including 300 Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. The Helpline also has a counselor on staff to take calls that require extended active listening prior to referring the caller on to appropriate local services. About 65 percent of callers are from the general public, and about 35 percent are local agency personnel.

/2008/ The MCH Helpline staff answer two 800 lines: 1) 80054502200 (MCH); and 2) 800-843-6154, option #5 (IDHS Customer Service Line). The staff of two field about 1,000 calls per month, including Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. About 65 percent of callers are from the general public, and about 35 percent are local agency personnel. The automated WIC/EI Referral Line assists approximately 1,700 callers per month with locating their local WIC and/or EI office. //2008//

The Illinois Department of Public Health. As a result of the reorganization of state human service agencies in 1997 (Public Act 89-0507), IDPH retains responsibility for the following statutes and MCH programs: the Phenylketonuria Testing Act, which supports the newborn metabolic screening program; the Counties Code, which supports the Sudden Infant Death Syndrome program; the Illinois Lead Poisoning Prevention Act, which supports the Childhood Lead Poisoning Prevention Program; and the Prevention of Developmental Disability Act, which supports the perinatal care program. IDPH also operates the Vision and Hearing Screening Program and the Oral Health Program. IDHS and IDPH annually execute an interagency agreement regarding the coordination of MCH services provided or funded by each agency.

The University of Illinois at Chicago Division of Specialized Care for Children. The University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC) administers the CSHCN program. DSCC is staffed to accomplish its traditional role of providing care coordination, accessing financial support for needed services, and advocating for high quality specialty services for CSHCN. Through a network of 13 regional offices and more than 60 satellite locations, DSCC maintains a strong focus on capacity building through family-centered, community-based care coordination activities and local systems development within all 102 counties in Illinois.

/2009/ DSCC currently has 40 satellite locations. //2009//

The Director of DSCC has available consultation and assistance from a major state university, including a School of Public Health, Colleges of Medicine, Nursing, Associated Health Professions and Education, as well as numerous associated health facilities and programs. A statutory Medical Advisory Board composed of medical community leaders from across the state and a family representative meet three times per year to counsel the Director on program policy and activities. In addition, consultation and assistance is also available from the DSCC Family Advisory Council (FAC) which meets three times per year and has family member representation from all 13 regions of the state. The FAC Chairperson also serves as the family member

representative on the DSCC Medical Advisory Board.

Frequent, close liaison is maintained with all major public and private agencies involved in services for CSHCN. DSCC has leadership and/or membership involvement with the following CSHCN-related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities, the Illinois Academy of Family Physicians, the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Illinois Interagency Transition Consortium, Brain and Spinal Cord Injury Advisory Council, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, Illinois Campaign for Better Health (State Children's Health Insurance Program Work Group), Illinois Department of Public Health Hearing Screening Advisory Board, Illinois Department of Public Health Vision Screening Advisory Board, Department of Human Services School Health and School Nurse Advisory Boards, IFLOSSS (Coalition for Access to Dental Care), Healthy Child Care Illinois Steering Committee, and the UIC-SPH MCH Training Program. DSCC also has collaborative activities with Shriner's Hospitals for Children in Chicago.

//2008/ DSCC has four delegates, including a staff parent representative, to the Association for Maternal and Child Health Programs (AMCHP). The Director is the co-chair for the AMCHP Workforce Development Committee. DSCC staff attend the annual meetings to stay abreast of national issues. //2008//

//2010/ Two representatives attended the AMCHP meeting. The interim director of DSCC is a member of AMCHP. //2010//

In addition to senior DSCC staff participation on interagency boards, councils and task forces at the state level, regional office staffs have developed and participate in numerous community working groups which involve local leaders and parent groups. These activities are exemplified by the regional staff involvement in the AOK Early Childhood Networks, the Illinois Project for Local Assessment of Needs (IPLAN) process, Early Intervention Local Interagency Councils and Transition Planning Committees.

For additional information, please visit the DCHP web site (www.dhs.state.il.us/chp), the DSCC web site (www.uic.edu/hsc/dsc) or the IDPH web site (www.idph.state.il.us).

D. Other MCH Capacity

Other MCH Capacity

IDHS. There are a total of 221 FTE positions in the Department's MCH program. There are 94 FTE positions at the central office in Springfield. Regional staff are deployed as follows: Region 1 (Chicago), 87 FTEs; Region 2 ("collar counties" and northern Illinois) eight FTEs; Region 3 (north central Illinois) twelve FTEs; Region 4 (south central Illinois) twelve FTEs; and Region 5 (southern Illinois) eight FTEs. Regional staff are generally Masters prepared maternal and child health nursing consultants, nutrition consultants and regional representatives involved in quality assurance and technical assistance. Central office staff includes 73 FTE professional and technical positions, and 21 FTE support staff positions. Statewide, the professional staff includes 21 registered nurses, 11 registered dietitians, and two social workers. At the time this application was submitted, 13 full-time positions were vacant.

Steven J. Guerra, Director of the Department's Division of Community Health and Prevention, is Illinois' Title V Director. He joined the IDHS in 2003 as the Associate Director for Prevention in the Division of Community Health and Prevention. He has had a distinguished 30-year career in human and community development. He has served and worked in the city and state government, social services, and the foundation communities. Mr. Guerra was appointed to serve as the Director of the Division of Community Health and Prevention in November of 2004.

He holds a bachelor's degree in economics and a Master of Business Administration degree.

/2009/ Ivonne Sambolin is the Director of the Division of Community Health and Prevention (DCHP), Illinois Department of Human Services. Prior to assuming this position, Ms. Sambolin was Special Projects Coordinator for the Division's Bureau of Youth Services and Delinquency Prevention, and served as the Project Coordinator for the federal GEAR UP Program. In August 2007, Steven Guerra became the Governor's Deputy Chief of Staff for Social Services. //2009//

/2008/ In October 2006, Myrtis Sullivan, M.D., M.P.H., was appointed Associate Director for Family Health, Division of Community Health and Prevention and Illinois' Title V Director. Dr. Sullivan received her M.D. and M.P.H. degrees from the University of Illinois at Chicago. She is a licensed Pediatrician, and has an extensive background in Maternal and Child Health. She has served and worked in areas of pediatric emergency services, environmental health, asthma, breastfeeding promotion, and community-based collaborative research. Dr. Sullivan has authored and coauthored several books/chapters, journal articles, and various published reports and abstracts pertaining to health and medicine practices, pediatrics, and community-based collaboratives. //2008//

DSCC. DSCC employs 196 FTEs to provide enabling services from local offices within the DSCC regional office system. Seventy-four FTEs in the Springfield Central Administrative Office provide necessary infrastructure support (system/policy development, core program technical assistance, administrative support, fiscal and information management, and personnel services) for the regional offices' care coordination system. An additional administrative office on the UIC campus accommodates six FTEs who provide Home Care Waiver Program technical assistance and administrative support activities. Over the last three years, administrative staffing in the Springfield Central Administrative office has been reduced by ten percent as a result of budget cuts. With those reductions, the available number of staff (administrative support, fiscal management, information systems support, and human resources) to support services to the field office care coordination staff have been impacted. Statewide temporary positions have been eliminated and overtime has been limited to support clinics and emergency situations with minimal impact in providing assistance to families. DSCC also provides direct services through the Children's Habilitation Clinic at UIC, which is staffed by five FTEs, including a developmental pediatrician, a clinical practice nurse specialist, clinical psychologist, medical social consultant, and support staff. Ancillary services such as physical therapy and speech pathology are obtained through contracts.

Charles N. Onufer, M.D., is the DSCC Director. In this capacity, he is responsible for planning and directing the State of Illinois' Program for Children with Special Health Care Needs. Dr. Onufer serves as Chairman of the Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities and also on other state Committees, including the Illinois Interagency Coordinating Committee on Transition, the Genetic and Metabolic Disease Advisory Committee, Vice President of the Brain and Spinal Cord Injury Advisory Council, Co-Chairman of the AMCHP Best Practices Committee, Chairman of the Medical Home Work Group for HRSA Region 4 Genetics Collaboration Committee, and is on the Planning Committee for the annual national MCH Leadership Conference Translating Research into Practice, implemented by the UIC-SPH Maternal and Child Health Program. Dr. Onufer is collaborating with over 30 other CSHCN programs to publish a biannual family newsletter, Special Addition, for families. Dr. Onufer is a Board certified Pediatrician, a Fellow of the American Academy of Pediatrics, and an Assistant Professor of Pediatrics at UIC. He received his Doctor of Medicine degree from Ohio State University and completed his pediatric and fellowship training from Tripler Army Medical Center and Madigan Army Medical Center, respectively.

/2008/ The AMCHP Best Practices Committee has been renamed the AMCHP Workforce Development Committee. //2008//

/2009/ Currently DSCC employs 193 FTEs to provide enabling services from local offices in the

DSCC regional office system and 59 FTEs in the Springfield central administrative office. The administrative office located at UIC in Chicago employs 6 FTEs and CHC employs 4.2 FTEs. DSCC re-aligned some support activities related to care coordination services so that the care coordinators' caseloads could be increased without having a negative impact on access to care coordination services. This was necessary in order to eliminate or move some positions within the agency. Through this realignment, professionals and paraprofessionals work in teams on each caseload and provide assistance to families more efficiently than our previous service model. Training was provided for all care coordination teams to improve their functioning. In addition, DSCC simultaneously streamlined the application forms and enrollment process. //2009//

/2009/ Dr. Onufer retired effective May 31, 2008. Gerri Clark, RN, MSN, has been appointed interim director. She has served as the Associate Director for Program Services at DSCC for the past nine years and held various positions in the Nebraska CSHCN program for seven years prior to coming to DSCC. //2009//

E. State Agency Coordination

State Agency Coordination

For a description of the organizational relationship among Illinois' human services agencies directly involved in the Title V program please refer to Organizational Structure.

Interagency agreements among IDHS, IDPH and DSCC are on file at the Division of Community Health and Prevention's headquarters in Springfield.

IDHS, IDHFS, and IDPH are strengthening the state infrastructure for program planning and development through a three-way agreement for exchange of data for program planning, monitoring and evaluation. The agreement involves the exchange of vital records, Medicaid eligibility and service delivery, MCH and other program management data.

/2009/ The Family Case Management Act requires the Department to create a Maternal and Child Health Advisory Board. The board met for the first time on January 23, 2008 and met again on April 30th. This new board will strengthen state, regional, and local relationships for the coordination and integration of Title V with other state and federal programs. //2009//

/2009/ In FY '07 a Re-structuring Task Force recommended development and implementation of Risk Screening Tools that would stratify service delivery requirements within the Family Case Management program. The work of this task force continued in FY'08, with further revisions to Prenatal, Infant and Child Risk Screening Tools, with input from IDHS MCH Nurse Consultants and a subset of MCH Advisory Board members. Additionally, draft changes to the Illinois MCH Code are being discussed. Changes in Federal rules governing case management services will necessitate revisions to how case management services are provided in a number of Illinois programs, beginning as early as late FY'08 and continuing into FY'09. //2009//

The Family Case Management Act requires the Department to create a Maternal and Child Health Advisory Council. This new council will strengthen state, regional, and local relationships for the coordination and integration of Title V with other state and federal programs.

IDHS and DSCC collaborate to implement a variety of programs to serve the MCH and CSHCN populations. This collaboration includes both informal and formal linkages for service delivery.

/2010/ IDHS, DCFS and ISBE are working together to develop the state's infrastructure to support evidence-based home visiting programs. These three agencies provide program grants to support three different approaches to home visiting for the purpose of supporting families and reducing the risk of child maltreatment. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The

three agencies are working with the Home Visiting Task Force, a broad-based advisory group of service providers, advocates and parents established by the Early Learning Council. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment."/2010/

/2010/ The State of Illinois is embarking on a project to design an information system that encompasses its human services delivery system. With leadership from Governor Pat Quinn, seven state agencies responsible for the delivery of healthcare and human services have prepared a Planning Advance Planning Document (PAPD) to examine the feasibility of developing an enterprise solution to support the essential tasks of service provision -- intake, assessment, application, eligibility determination, casework, and provider management. The departments participating in this project are the Departments on Aging, Children and Family Services, Commerce and Economic Opportunity, Employment Security, Healthcare and Family Services, Human Services and Public Health." The objectives for the Framework are to: 1) expedite and simplify access to services; 2) streamline administration and data sharing; 3) return focus of front line staff to casework; 4) maximize capture of Federal Financial Participation; 5) enhance planning capacity, program evaluation and fraud detection/prevention with access to cross-agency data; and 6) simplify service delivery for contracted providers./2010/

Other Divisions Within The Illinois Department of Human Services. To enhance continuity of care for CSHCN, DSCC collaborates with IDHS' Division of Rehabilitation Services (DRS) in the following areas that benefit CSHCN: vocational rehabilitation services for clients at or near employable age; home services programs to avoid unnecessary institutionalization; education and habilitative services for children requiring education programming outside their communities; independent living programs; referral process for children determined medically eligible for SSI, and transition of DSCC Home Care Waiver children to the DRS Home and Community-Based Services Waiver Program.

Through systems change efforts, DSCC and DRS have increased collaborative efforts targeted at transition planning for CSHCN. Additionally, a three-agency agreement is in place between DSCC, DRS, and IDHFS to facilitate the transition of children from the waiver for medically fragile, technology dependent children operated by DSCC to the Home Service Program, which is another Home and Community-Based Services waiver operated by DRS for persons with disabilities through age 59.

DSCC maintains a Memorandum of Understanding with the Early Intervention Program to coordinate activities, including referral between the two programs and is designated in state law as a member of the Illinois Interagency Council on Early Intervention. In addition, DSCC provides training and technical assistance for Early Intervention Service Coordinators.

The Division of Community Health and Prevention collaborates with other Divisions within IDHS to improve the coordination and effectiveness of Title V programs as follows: DCHP and the Division of Human Capital Development collaborate to help TANF families move from welfare to work through intensive casework services that connect them to IDHS programs and benefits they need, and to local community resources where other services are provided. DCHP and the Division of Mental Health collaborate to promote the integration of service systems in order to provide a comprehensive array of mental health and support services to children and their families. DCHP and the Division of Alcoholism and Substance Abuse collaborate to coordinate and fund community-based services throughout the state for the prevention, intervention, treatment, and rehabilitation of alcohol and other drug abuse and dependency for at-risk or addicted individuals and their families.

/2009/ DCHP, the Division of Mental Health and the Division of Alcoholism and Substance Abuse

and the Division of Mental Health sponsor an annual conference for service providers entitled, "Transforming Community Systems for Prevention, Treatment and Recovery" in order to disseminate best practices and facilitate service system integration at the community level.
//2009//

//2010// DSCC continues to serve as the entity for application to the Institute and provides family scholarships. //2010//

Through an interagency agreement, the Illinois School for the Deaf, Early Intervention, Illinois Department of Public Health, Illinois State Board of Education, and DSCC collaborate to provide the annual Institute for Parents of Preschool Children Who Are Deaf or Hard of Hearing, to enhance the knowledge of parents of infants and toddlers and provide multi-disciplinary evaluation. In 2004, 2005 and 2006, DSCC provided family scholarships to families who attended the Institute to supplement the loss of income because of the week-long commitment.

IDHS and DSCC coordinate with other State agencies as noted below: Illinois Department of Healthcare and Family Services. IDHS and IDHFS have an Interagency Agreement for the coordination of Title V, Title XIX, and Title XXI program activities. This agreement allows each agency to refer eligible clients to the other for services. The two agencies have a separate agreement for the Family Case Management initiative that enables IDHFS to claim federal matching funds through the Medicaid program for outreach and case management activities conducted by the Family Case Management program. IDHS and IDHFS have arranged for local health departments to claim federal matching funds through the Medicaid program for local expenditures that support the Family Case Management program. For SFY'05, \$7.6 million in federal matching funds have been reimbursed to local health departments. Eightysix local health departments participate in the Family Case Management administrative claiming process.

/2008/ For SFY'06, \$8.6 million in federal matching funds have been reimbursed to local health departments. Eighty-six local health departments have signed intergovernmental agreements to participate in the Family Case Management administrative claiming process. //2008//

//2010/ For SFY'07, \$11.6 million in federal matching funds have been reimbursed to local health departments. Eighty-six local health departments participate in the Family Case Management administrative claiming process.

For SFY'08, \$14.1 million in federal matching funds have been reimbursed to local health departments. Eighty-six local health departments participate in the Family Case Management administrative claiming process.//2010//

Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for determining eligibility of pregnant women and initiating the All Kids (Title XIX and Title XXI) application process for children under 19 years of age. An annual notice is mailed to all families eligible for Title XIX or Title XXI (except individuals residing in long-term care facilities) to inform them of the WIC program and provide them with the Department's Health and Human Services hotline number.

/2009/IDHFS maintains an interagency agreement with DSCC. It includes a description of each agency's responsibilities in implementing the home and community-based services (HCBS) Section 1915 (c) waiver for medically fragile, technology dependent children under the age of 21. The agreement also facilitates claiming federal matching funds for care coordination under the HCBS waiver and for Medicaid-eligible children in DSCC's Core Program. The agreement is reviewed annually and updated as necessary. DSCC's responsibilities are outlined in detail in the agreement. DSCC provides care coordination, utilization review, and conducts quality assurance activities including oversight of nursing agencies and providers of durable medical equipment that serve the children in the waiver. IDHFS funds the program and maintains final approval of waiver eligibility, plans of care and hearing decisions. DSCC is also an All Kids application agent. The

IDHFS and DSCC meet at least quarterly to discuss policies and issues directly associated with implementing the HCBS waiver program. /2009/ CMMS rules for targeted case management potentially will affect DSCC. DSCC is working with HFS to address necessary changes. //2009//

Illinois Department of Public Health. IDHS works with many divisions and programs within IDPH to develop preventive and primary care systems. IDPH and DSCC provide otologic/audiologic clinics in communities with high rates of children who receive no follow up after failure of school hearing screenings. A Memorandum of Understanding delineates collaborative activities for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, and Hearing Instrument Consumer Protection programs.

/2008/ The Memorandum of Understanding with DSCC and Public Health is being updated to include Newborn Hearing Screening and APORS. //2008//

/2009/ The IDPH MOU was signed by IDPH in August 2007, and by the University of Illinois Chicago in October 2007. //2009//

/2010/ IDPH began referring infants in the Adverse Pregnancy Outcomes Reporting System (APORS) Program to DSCC and Early Intervention (EI) in the fall of 2008. //2010//.

IDPH, IDHS, and DSCC collaborate on the state's Universal Newborn Hearing Screening Program to enhance system development and implementation. DSCC has taken on responsibility for statewide system development activities related to this program. DSCC applied for and received the Universal Newborn Hearing Screening and Intervention Grant.

/2008/ The HRSA Universal Newborn Hearing Screening grant will end in March 2008. //2008//

/2009/ DSCC was awarded the Universal Newborn Hearing Screening and Intervention: Reducing Loss to Follow-up after Failure to Pass Newborn Hearing Screening grant. //2009//

/2009/ A legislative initiative last year to support the program through the assessment of a fee for each newborn was unsuccessful. A bill has been introduced to appropriate funds to IDPH, DSCC and IDHS to sustain the program. //2009//

In 1999, the Illinois Department of Public Health received funding from the U.S. Centers for Disease Control and Prevention to build capacity and to develop a state plan to address asthma. As a result, the Illinois Asthma Program was formed and a statewide partnership was developed. The Partnership meets semi-annually, in addition to annual regional trainings and a yearly asthma conference. Five work groups and community asthma coalitions assist with the partnership's efforts. The Illinois Asthma Program (IAP) funds four coalitions to implement asthma state plan goals and funds a number of communities to develop asthma coalitions to begin to address asthma for World Asthma Day and funded 29 WIC clinics to provide asthma education to staff and clients.

IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level and on the statewide subcommittees by MCH Nurse Consultants, Child Care Nurse Consultants, and School Health staff. Activities in 2005 included the distribution of asthma toolkits to child care providers. The Healthy Child Care Illinois nurse consultants ensure the distribution of the toolkits and will provide education about asthma. Other activities include offering an asthma calendar contest for Illinois fifth and sixth grade students and hosting an annual satellite program, which focused on a comprehensive approach to asthma management in schools. The program was held to educate school staff and parents on the management of asthma and the various components (roles of school staff, physical activity, medications and action plans and environmental and pest management issues) of an asthma management plan.

/2008/ IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is represented at the advisory level and on statewide subcommittees by Public Health Nurse Consultants, Child Care Nurse Consultants, and School Health staff. Activities in 2006 included the distribution of asthma toolkits to child care providers, an asthma calendar contest for Illinois fifth and sixth grade students, and hosting an annual satellite program, which focused on asthma and physical activity in schools. The program was held to educate school staff and parents on the management of asthma and to differentiate asthma and exercise-induced asthma, triggers, prevention strategies, medications, peak flow meters, asthma action plans, and how schools can develop a school or school district emergency plan for asthma. //2008//

/2010/ School-based health centers in Cahokia and East St. Louis participated in a project designed to improve identification of students with asthma, assessment of current disease management and provision of health education and treatment in keeping with national guidelines. School nurses have been surveyed through DHS educational offerings on prevalence of asthma and management practices //2010//

Illinois State Board of Education (ISBE). Although there is no formal agreement with the ISBE, program staff from the DSCC central office coordinate with State Board staff regarding issues for CSHCN in schools. DSCC distributes to families via its regional offices, "A Parent's Guide: The Educational Rights of Students with Disabilities," published by ISBE. DSCC regional office care coordinators work with the local schools regarding individual issues in the educational setting.

ISBE no longer employs a school health consultant and refers questions on school health related issues to the IDHS School Health program staff and to the appropriate programs within IDPH. The School Health program staff worked with the ISBE and a State Advisory Committee to publish numerous documents, including: Recommended Guidelines for a Medication Administration in Schools; Asthma Management: A Resource Guide for Schools; Diabetes in Children: A Resource Guide for School Health Personnel; First Aid Procedures for Injuries and Illnesses; Certificate of Child Health Examination; and Health Status of School Age Children and Adolescents in Illinois. Copies of these documents have been sent to all public and private schools in the state, as well as advocacy groups and individuals interested in these issues. The documents are also available electronically on the DHS School Health Program web page. ISBE staff assist in the review of applicants for new School health centers and coordinated school health program grants.

Schools. A variety of programs are operated through schools to meet the needs of children and adolescents. First, the school health centers work through primary care providers to deliver comprehensive medical, mental health, dental and preventive health education services to school age children and parenting students. These clinics coordinate care provided to their clients with the clients' primary care provider. The clinics refer the client for specialty care as needed and seek third party reimbursement for services provided. Second, IDHS works with 12 local health departments to implement coordinated school health programs. Third, the MCH program also conducts continuing education programs for school nurses and administrators and provides regular updates on school health issues through email and the publication of the School Health Dimensions newsletter. Finally, schools are also the main delivery sites for the Unmarried Parents and Youth Opportunity programs.

Illinois Department of Children and Family Services. DSCC collaborates with the Illinois Department of Children and Family Services (DCFS) on behalf of state wards of DCFS who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To enhance system collaboration, DSCC staff are available to provide in service training as needed on CSHCN to local and regional DCFS staff throughout the state. MCH program staff work with DCFS on the management of HealthWorks of Illinois, described earlier in this application.

/2009/ DSCC care coordination staff took advantage of available DCFS online training for

mandated reporters. //2009//

Illinois is one of seven states selected to pilot Strengthening Families Through Early Care and Education. The Illinois Department of Children and Family Services (DCFS) initiated Strengthening Families Illinois through a collaboration of 30 partner organizations and state agencies from child welfare, child abuse prevention, and early childhood fields as well as parents and community leaders. Local learning networks have been established at five childcare centers across the state to work with families to build protective factors around children to prevent child abuse and neglect. The Child Care Nurse Consultants were trained to provide instruction about the protective factors to childcare providers throughout Illinois. The childcare providers will be prepared to recognize and develop parental resilience, foster social connections, increase knowledge of parenting and child development, provide concrete support in times of need for parents, and learn about the healthy social and emotional development of children. DCFS and IDHS collaborate on the operation of HealthWorks of Illinois, which establishes regional networks of primary and specialty care to ensure that children in foster care receive the health care services they require.

F. Health Systems Capacity Indicators

Introduction

/2008/ The IDPH Genetics/Newborn Screening program is developing an interface with the birth record. In 2007, a vendor, Pekin-Elmer, was selected to develop a web-based Newborn Metabolic Screening Data System that will interface with the birth record to ensure that all Illinois infants are screened. //2008//

/2008/ The data-sharing infrastructure in IL has been strengthened through a three-way agreement for exchange of data for program planning, monitoring, and evaluation between IDPH, IDHFS, and IDHS. It involves exchange of vital records, Medicaid eligibility and service delivery, MCH and other program management data. //2008

/2008/ In FFY07, Illinois' application for SSDI funding addressed the need to develop capacity to "mine" the MDW for pertinent data and approach the data from an epidemiological perspective. //2008//

/2008/ An epidemiologist and data analyst will be hired through the SSDI project to assist in accomplishing these goals. //2008//

/2009/The SSDI Data Analyst position was filled. Christine Brophy, who has extensive background in IT and experience with numerous analytical software packages became a member of OPPD in December 2007. The Division of Community Health and Prevention applied for a CDC/CSTE MCH Epidemiological Fellow. Beginning July 2008, Amanda Bennett began her fellowship.//2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	64.1	66.1	66.3	59.7	60.6
Numerator	5708	5886	6024	5325	5416
Denominator	890545	890545	909278	891315	894368
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Hospital discharge data that were made final and available in 5/2009. The addition of additional diagnoses codes in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Notes - 2007

Hospital discharge data that were made final and available in 8/2008. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau.

Notes - 2006

The number of non fatal injuries is hospital discharge data that were made final and available in 8/2007. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau. (Revised 9/5/08)

Narrative:

In 2008 (the most recent data available), the rate of asthma hospitalization among children under five years of age was 60.6 per 10,000,. Although slightly higher than the rate reported in 2007, it is a distinct improvement as compared to earlier rates. The MCH program supports two demonstration projects to improve asthma management in young children; these activities were described earlier in the application.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	95.0	87.2	87.3	86.2	84.4
Numerator	68234	64135	66245	71434	70928
Denominator	71826	73578	75921	82892	84031
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Source: Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Received in May 2009, the data are provisional and are extracted from the Annual EPSDT Participation Report for FFY2008 (CMS-416). As always providers have up to one year to submit claims which is why these data are still provisional.

Notes - 2007

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from

IDFHS 7/9/08. 2007 data are provisional.

MCH has not received final data for 2007 as of May 2009.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Data from report used to prepare the CMS 416 report. Received from IDFHS 7/9/08.

Narrative:

The proportion of Medicaid-eligible infants that obtain routine well-child care is large, 84 percent in 2008. However, since 2004 when this indicator was at its peak of 95 percent, the proportion has decreased as the number of eligible clients increased. Since 2004, the number of eligible infants has increased 17 percent. Income thresholds were raised allowing more families to participate in state-sponsored care.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	98.1	97.5	97.2	89.3	95.8
Numerator	987	842	1009	1612	1359
Denominator	1006	864	1038	1805	1418
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

The methods to arrive at the numerator and denominator are not known. HFS points to the source - HEDIS - Well Child Visits in the First 15 Months of Life - a summary report as of 1/22/09.

Notes - 2007

Source: The source of the 2006 data report are the same with the exception of the word "HEDIS" included in the overall title - Executive Information System, HEDIS - Well Child Visits in the First 15 Months of Life (W15). Summary report "Title Specific Report - All HFS Enrolled" as of 11/16/2007, HCFS.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Well-Child Visits in the First 15 Months of Life" - data as of 3/30/2007. Only Title XXI reported here. Data are Provisional as of June 7, 2007.

Narrative:

Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP in 2008 was 1,418, and almost 96 percent of these infants received at least one well-child service.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	78.8	80.2	79.9	80.0	80
Numerator	132359	133556	135403	132894	
Denominator	167931	166527	169481	166171	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

Data are not available from IDPH for 2008 births.

Notes - 2007

At the time of this application, 2007 data is not available. An estimate is being provided at this time.

Notes - 2006

Source: Center for Health Statistics - IL Department of Public Health The 2006 provisional data have been finalized in May 2009.

Narrative:

The proportion of women who received an adequate number of prenatal care visits has been steadily increasing, as measured by the Kotelchuck Index. In 2007, 80.0 percent of women who gave birth received an adequate amount of prenatal care as measured by the Kotelchuck Index.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	72.3	71.1	70.0	66.2	67.0
Numerator	638376	713621	754192	860024	986108
Denominator	883192	1003893	1078065	1298701	1471976
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Source: CMS 416 FFY09 Annual EPSDT Participation Report from HFS.

The provisional data are the total of children who should receive at least 1 screen and the total individuals eligible for EPSDT, also known as the 'participant ratio' (0.665). The total eligibles with at least 1 screen produces a percentage of 45.

Notes - 2007

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Kidcare Performance Review Request #3.1 - Claims Paid Up To and Including 6/27/08. Title XIX and Title XXI included. The report is based upon the number of children eligible during CY2007.

Notes - 2006

Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. Report titled "Kidcare Performance Review Request #3.1 - Claims Paid Up To and Including 4/30/08. Title XIX and Title XXI included. The report is based upon the number of children eligible during CY2006.

Narrative:

The expansions of health care coverage in Illinois have increased the proportion of potentially Medicaid-eligible children by 66 percent since 2004. From 2007 to 2008, the most recent years for which data are available, the number of potentially Medicaid-eligible children increased by 13 percent. There was a 15 percent increase in the number of children receiving a service between 2007 and 2008 and the overall proportion slightly increased in this time frame.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	42.8	47.4	52.2	52.2	57.8
Numerator	104284	131667	161447	161447	173546
Denominator	243792	277819	309570	309570	300482
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Source: Provisional Annual EPSDT Participation Report FFY 2008. As always providers have up to one year to submit claims to HFS.

Notes - 2007

No data released for 2007. Using 2006 data as provisional. Data from the Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. No report title given.

Notes - 2006

Source: Illinois Department of Healthcare and Family Services, Bureau of Maternal and Child Health Promotion. No report title given. These 2006 data are made final in year 2008.

Narrative:

The proportion of Medicaid-eligible children between six and nine years of age who received any dental services reached 57.8 percent in 2008, a significant increase when compared to earlier years.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	13.3	11.6	8.3	8.7	10.2
Numerator	5101	4649	3155	3286	3854
Denominator	38439	40110	37981	37673	37755
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006

The annual indicator is an estimate that includes two populations served by DSCC, including children who were newly eligible for SSI who receive information and referral services and SSI eligible children who also receive services through the Core and Home Care Program. Some number of children could be dually counted in these two groups.

Narrative:

Children with Special Health Care Needs. The proportion of state SSI beneficiaries under 16 years of age who received rehabilitative services through the CSHCN program increased to 10.2 percent in 2008 (Health Systems capacity Indicator 8, Form 17). For a description of DSCC's efforts for SSI-eligible children, see Section III.B., "Agency Capacity", "Children with Special Healthcare Needs."

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	matching data files	9.1	7.5	8.5

Notes - 2010

2007 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, September 2009.

Narrative:

//2010/ In 2007, the percent of low birth weight births was higher among Medicaid-eligible infants (9.1 percent) than non-Medicaid eligible infants (7.5 percent). The percent distribution of low-birth weight among Medicaid and non-Medicaid infants is similar to previous years in that it is higher among Medicaid-eligible infants. //2010//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	8.1	6.1	7.4

Notes - 2010

Source: 2006 Matched death birth file, from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, August 2008. 2007 death data is not available at the time of this report submission. There is no indication from IDPH when the 2007 data will be available.

Narrative:

//2010/ As in previous reports, the rate of infant mortality is higher among Medicaid-eligible infants (8.1 deaths per 1,000 live births) than non-Medicaid-eligible infants (6.1 deaths per 1,000 live births). These statistics are derived from the latest available data, calendar year 2006. //2010//

Health Systems Capacity Indicator 05C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	75.5	88.3	86

Notes - 2010

2007 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, September 2009.

Narrative:

/2010/ Improvement in the percent of infants born to women receiving prenatal care in the first trimester was reported across income groups in 2005 as compared to 2004, and then again in 2006 as compared to 2005. However, the rate leveled-off in 2007 for the Medicaid-eligible population. The percent of births receiving prenatal care in the first trimester among Medicaid-eligible was 75.5 in 2007, 76.3 in 2006, 74.3 in 2005 and 71.9 in 2004. The percent among non Medicaid-eligible was 88.3 in 2007, 88.2 in 2006, 87.4 in 2005 and 83.4 in 2004. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	73.4	86.8	80

Notes - 2010

2007 Birth file from IDPH matched to Medicaid data by DHS, Community Health & Prevention, Performance Support Services, September 2009.

Narrative:

/2010/ As compared to 2004, greater percentages of women regardless of payment source were receiving adequate prenatal care according to 2005 vital statistics data. That trend continued into 2006, however there was a modest decline in 2007. For Medicaid-eligible women, the percent receiving adequate prenatal care was 70.5 in 2004, 73.0 in 2005, 73.8 in 2006 and 73.4 in 2007. Non-medicaid eligible women reported a modest increase in the percent receiving adequate prenatal care from 2004 to 2005, 86.6 to 87.4 percent, respectively, but then showed a reversal in 2006 with a rate of 88.2 percent, and then improved in 2007 with a rate of 86.8. These observed increases were reflected in the percent differences for the entire birth cohort; in 2004, 78.8 percent of pregnant women received adequate prenatal care, in 2005 it was 80.0, in 2006 it was 79.9 and in 2007 it was 80.0 percent. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and	YEAR	PERCENT OF POVERTY LEVEL Medicaid
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pregnant women.		
Infants (0 to 1)	2008	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2008	200

Narrative:

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP. Eligibility for children under SCHIP is 200 percent of the federal poverty level.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200

Narrative:

Children over one year-of-age from families with incomes below 133 percent of the federal poverty level are eligible for Medicaid; children from families with incomes between 133 and 200 percent of the federal poverty standard are eligible for SCHIP. All other uninsured children, regardless of income or citizenship, are eligible for All Kids.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2008	200

Narrative:

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP. Eligibility for children under SCHIP is 200 percent of the federal poverty level.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010**Narrative:**

Amanda Bennett, MPH began a 2-year assignment to the Illinois Department of Human Services through the CDC/CSTE Applied Epidemiology Fellowship in June 2008. Since then, she has worked on several data projects related to maternal and child health, including:

Restructuring administrative program data (from Cornerstone system) to make it useful for epidemiologic analysis. The Cornerstone system is a relational database, which makes it difficult to use for epidemiologic studies because information for a given individual is not all stored together. By taking the time to combine the relational tables into a single dataset, detailed program data will be able to be used in future epidemiologic studies.

Conducting a detailed outcome evaluation of the Family Case Management (FCM) program. This project involves linking birth certificates to the restructured Cornerstone tables in order to examine different elements of program dose on low birth weight. This is the first attempt to try to understand how the number of visits, timing of visits, location of visits (e.g. home vs. in office), and length of time spent with the case manager impact health outcomes. As well, stratified analyses will be conducted to determine if the "dose-response" curve is different for different sub-groups of participants. The results of this project will be used to inform decisions about restructuring the FCM program.

Analyzing trends over time in cesarean section rates and related maternal morbidities. Because national rates of c sections have been rising over the last decade, the Illinois Department of Public Health, Office of Patient Safety and Quality initiated this project to determine if Illinois is following these trends. Ms. Bennett is using state hospital discharge data to conduct this analysis and IDPH will produce a data report for public circulation upon its completion.

In the upcoming year, Ms. Bennett will complete these projects, as well as conduct a time trend analysis of preterm delivery and an in-depth analysis of the Pregnancy Risk Assessment Monitoring System (PRAMS) survey for use in the Title V Block Grant 2010 Needs Assessment.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Youth Tobacco Survey	3	No
Illinois Youth Survey	3	Yes

Notes - 2010

Narrative:

The 2008 version of the Illinois Youth Survey reports that the percent of students in 8th, 10th, and 12th grades who had smoked cigarettes decreased to 12.5 percent from 2002 when the percent was 18.9 percent. In 2008, 4.1 percent of the students used "other" tobacco products (primarily smokeless tobacco).

IV. Priorities, Performance and Program Activities

A. Background and Overview

Background and Overview

The Illinois Title V program uses a performance management model to guide its program efforts. After choosing a set of priority needs from the five year statewide needs assessment, resources are allocated and programs are designed and implemented to address these priorities. These program activities are described and categorized by the four levels of the MCH pyramid: direct health care; enabling; population based; and infrastructure building services. Imbedded within the levels of service are sets of national core performance measures and eight state negotiated performance measures categorized into three types: capacity, process, or risk factor. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies. The program activities, as measured by these core and negotiated performance measures, are expected to have a collective contributory effect that will positively impact the national outcome measures for the Title V program.

B. State Priorities

The role of the Title V program in Illinois is to empower communities to develop an appropriate infrastructure and to enable women and children, including children with special health care needs, to access the preventive, primary, and specialty services they require. To fulfill this role, the Title V program considers health status, demographic, health care financing, and legislative factors when setting priorities and developing new initiatives. The current priorities and corresponding initiatives of the Title V program include:

Maternal and Infant Health

1. Reduce racial disparities in infant mortality - The reduction of infant mortality has been a priority for Illinois' Title V program for many years. While Illinois' infant mortality rate is steadily improving, it still lags behind the nation in the racial disparity between African-American and Caucasian infant mortality rates remains greater than 2:1. The expert panel on maternal and infant health convened for the needs assessment recommended as its top priority that the Title V program focus on reducing racial disparities in infant mortality.

The IDHS and the IDPH will address this objective through statewide initiatives (WIC, Family Case Management and the regionalized perinatal care program) as well as targeted initiatives for high-risk populations (Targeted Intensive Prenatal Case Management, the Chicago Healthy Start Initiative, the Illinois Healthy Start Programs Partnership, Closing the Gap, and Healthy Births for Healthy Communities). The MCH program will also work closely with the IDHFS to fully implement the recommendations of the Perinatal Task Force for expansion of optional Medicaid services for the reduction of infant mortality and the improvement of perinatal health.

/2008/ New Infant Mortality (IM) Initiatives: 1) Illinois' Title V Director has joined the National March of Dimes "Big Five Prematurity Summit" in San Jose, California from May 21 - 23, 2007. This summit addressed prematurity, low birth weight, and other factors that contribute to infant morbidity and mortality. The states represented (New York, Illinois, Texas, Florida, and California) account for over one-third of the premature births in the U.S.;

2) IDHS will join the Illinois Maternal and Child Health Coalition in co-sponsoring a statewide

Infant and Maternal Mortality Summit in Chicago on October 24 - 25, 2007. This summit will bring key stakeholders (including elected officials, community-based agencies, health care and service providers) together to develop and implement a statewide strategic plan to improve infant and maternal outcomes in Illinois. //2008//

/2009/ The Illinois Maternal and Child Health Coalition sponsored a two-part summit on Maternal and Infant Health in order to focus attention on the racial disparity in infant mortality and to develop new approaches to addressing this problem. The 10 broad strategies recommended by the summit include:

1) Increase access to comprehensive sex education including family planning; 2) Access to affordable health care for all across the lifespan; 3) Provide children's allowances i.e. universal income based supports similar to European countries; 4) Provide maternity/paternity paid leave; 5) Ensure the quality of prenatal and general healthcare in all communities; 6) Integration of case management systems and provide local resources for communities to develop systems of care; 7) End racially discriminative policies and practices in public institutions-such as education and housing, and criminal justice; 8) Maintain effective and efficient health data systems that provide timely health information that can be used to generate action; 9) Institute a public campaign to improve community mores in support of pregnant women; and 10) Advocate for community economic development in areas of employment, housing, and education in a manner that engages and empowers communities. //2009//

/2009/ Local WIC agencies receive monthly racial/ethnic reports which are designed to help them provide enhanced targeted outreach to potentially eligible WIC populations. //2009//

/2009/ The Department in conjunction with the University of Illinois at Chicago will convene a one-half day conference entitled, "Toxic Pregnancy: Conference on Effects of Environmental Toxicant Exposure on Embryonic and Fetal Development." The primary aim of the conference is to increase knowledge of environmental toxins and increase practice behaviors relating to reduce prenatal exposure, among clinicians who provide health care to pregnant women. It will be held in Chicago on October 24, 2008. The objectives of the conference include increasing knowledge, attitudes, and practice behaviors related to environmental exposures during pregnancy. //2009//

//2010//The 10-point strategic plan from Summits I & II was further developed into the Campaign to Save our Babies (CSOB). The CSOB devised a pilot project to implement the 10-point action plan in an incubator community; Englewood, a low income neighborhood on the south side of Chicago). In addition to the CSOB, our Title V agency in partnership with the Illinois Maternal and Child Health Coalition (IMCHC) applied for and was awarded funding to participate in the Partnership to Eliminate Disparities in Infant Mortality (PEDIM), Action Learning Collaborative (ALC), sponsored by CityMatCH, AMCHP, NHSA. Dr. Sullivan and Robyn Gabel (CEO of IMCHC) are the co-leaders of the Illinois Collaborative.

DHS sponsored a statewide Breastfeeding Conference in April 2009. At that conference, the Illinois Blueprint for Breastfeeding Promotion was launched. The Blueprint is a joint effort spearheaded by DHS Bureau of Family Nutrition and HealthConnect One (formerly Chicago Health Connection).

Dr. Sullivan is a member of the recently funded Illinois Doula Project's Advisory Board.
//2010//

/2009/ The Illinois Birth to Five Project hosted a statewide Medicaid EPSDT Summit for state leaders. Dr. Myrtis Sullivan, Associate Director, Office of Family Health and Glendean Sisk, Program Administrator, Family Case Management attended. Modeled after the EPSDT State Leadership Summits, sponsored by the Maternal and Child Health Bureau-Health Resources and Services Administration of the U.S. Department of Health and Human Services, this Summit brought together 25-30 Illinois state leaders (public and private). Attendees included state

representatives from Medicaid, Title V, Part C, child welfare, individual providers, parent advocates, directors of model programs, and foundations. The Summit was facilitated by Kay Johnson of Johnson Group Consulting. The Summit took place in June 25 - 26, 2008 in Chicago. Through extensive discussion and two rounds of prioritization, the group consensus supported six priority areas for short-term action: 1. Boost mental health services capacity in community health centers/Federally Qualified Health Centers (FQHC), 2. Increase clinic capacity and recruiting dentists for safety net clinics, 3. Consultation from specialist and sub-specialist medical providers, 4. Increase provider reimbursement for pediatric specialists and sub-specialists, 5. Grow and develop the early childhood mental health workforce and, 6. Use All Our Kids (AOK) sites for development of community pilot projects serving children at-risk.//2009//

/2009/ The DHS Office of Family Health is collaborating with the The Chicago Health Connection (an advocacy organization that promotes breastfeeding and the Doula program) to plan breastfeeding promotion strategies for the entire state. These plans will include a breastfeeding summit to be held in Chicago in October 2008 and a WIC conference in April, 2009. //2009//

Progress will be monitored and reported in the Block Grant application and annual report through National Outcome Measure 2.

2. Reduce the rate of unintended pregnancy - This priority was identified through the needs assessment completed for the FFY'06 application, particularly among Medicaid-eligible women. In 2002, 43 percent of women who responded to Illinois' PRAMS survey indicated that their most recent pregnancy was mistimed or unwanted. The rate is as great as two-thirds among low-income women.

This objective will be addressed through the provision of family planning services through the Title X, Illinois Healthy Women and School Health Center programs, through the Abstinence Education and Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by the Family Case Management program, the Chicago Healthy Start Initiative, and Healthy Births for Healthy Communities. The IDHS will continue to work closely with IDHFS to coordinate the Family Planning program with Illinois Healthy Women (the Medicaid family planning demonstration waiver).

Annual performance will be measured through Illinois' PRAMS survey and reported in the Block Grant application and annual report through State Performance Measure 6.

/2008/ New Initiative: The Division of Community Health and Prevention at IDHS has developed a satellite videoconference on preconceptional and interconceptional care that will be distributed locally and nationally to promote well woman care and to educate and train care providers and other relevant professionals and stress the importance in incorporating strategies to improve well woman care at every service and medical visit. //2008//

3. Reduce the incidence of sexually transmitted infections, including HIV - This priority was selected because of the high rates and racial and ethnic disparities in sexually-transmitted infections in Illinois, including Gonorrhea, Chlamydia, and Human Immunodeficiency Virus, identified through the FFY'06 needs assessment.

The objective will be addressed primarily through the Family Planning and School Health Center programs. The IDHS Family Planning program has been an active participant in the Region V Infertility Project and the Illinois Infertility Project for many years. Both of these projects focus on the prevention of infertility through improved screening for Chlamydia through family planning and other sexually transmitted infection clinics. The IDHS and IDPH work together on both of these projects. The MCH program will also strengthen its collaboration with the IDPH AIDS Activity Section.

/2009/ IDHS and IDPH are collaborating on new ways to address the high rates of Chlamydia and

other STI's in Illinois. A meeting was held with IDHS and IDPH representatives in early March to identify potential strategies. A joint action plan will be released in the fall of 2008. //2009//

Annual performance will be reported in the Block Grant application and annual report through State Performance Measure 10. Chlamydia was selected for the performance measure because its incidence is increasing among adolescents and young adults.

Child and Adolescent Health

1. Reduce adolescent risk-taking behavior and racial and ethnic disparities in teen births - This priority was selected because of the high rates of adolescent risk-taking behavior (use of alcohol, marijuana and sexual activity) and the changing patterns of childbearing among racial and ethnic sub-groups of teens. The reduction of teen pregnancy has been a priority of the Title V program for many years, and the state's overall teen fertility rate and the proportion of all infants born to teen mothers continue to decline. However, the number of births to teens of Hispanic or Latino origin is increasing.

This priority will be addressed through the Teen Pregnancy Prevention programs (both Primary and Subsequent), the family support programs (Healthy Families Illinois, Parents Too Soon and Teen Parent Services), the Family Planning program, the Abstinence-Only Education program, the School Health Centers, and the community-based substance abuse prevention and youth service programs overseen by the Division of Community Health and Prevention.

Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 8.

2. Promote healthy growth and development of children - This priority was selected because of the increasing prevalence of childhood overweight in Illinois, as described in the FFY'06 needs assessment.

This priority will be addressed by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and by the School Health Centers. WIC's strategies to promote health growth and development are well known. The School Health Centers have implemented a Continuous Quality Improvement (CQI) process that includes health risk assessments of enrolled students and the development of interventions to reduce the incidence of overweight children. All of the health centers supported by IDHS will be addressing childhood overweight through this process. Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 14.

//2010/ In August 2009, the new WIC Food Packages will be released in Illinois. The new packages align with the Dietary Guidelines for Americans by increasing whole grains, fruits and vegetables, and reducing the amount of fat, saturated fat and cholesterol provided. //2010//

3. Improve access to preventive and primary health care services - This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC and Family Planning programs, the School Health Centers and the "Mini Block Grant" to the Chicago Department of Public Health. IDHS initiated two successful campaigns to improve the number of children in the WIC program who have health insurance and to improve the proportion of infants and children in Family Case Management and WIC who are fully immunized. Due in part to the success of the Family Case Management program, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate among infants exceeds 90 percent. School Health Centers will implement a CQI process to confirm the insurance status of enrolled children. The IDHS will also

continue to work closely with the IDHFS to enroll uninsured children in All Kids and ensure timely and efficient implementation of the All Kids initiative.

//2009/ The State of Illinois' primary strategy for addressing this priority is IDHFS Primary Care Case Management (PCCM) program, "Illinois Health Connect." IDHFS implemented PCCM to promote the use of medical homes for both children and adults and to reduce Medicaid expenditures arising from inappropriate use of specialists and emergency departments. Illinois Health Connect was described earlier in this application. //2009//

Annual performance will be reported in the MCH Block Grant application and annual report through National Performance Measures 13.

4. Improve access to mental health services - This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC, Teen Parent Services, Healthy Families Illinois, Parents Too Soon programs, the AOK Networks, and the School Health Centers. Local providers of these services have been trained to conduct developmental screening through the State Early Childhood Comprehensive Systems initiative and the performance of developmental screening is monitored each quarter. Children who appear to have a developmental delay are referred to the Part C Early Intervention program for further assessment. The All Our Kids Early Childhood Networks work closely with community agencies to improve developmental screening and to improve the transition from Part C to Part B services under the Individuals with Disabilities Education Act. Mental health consultation is available through Part C Early Intervention Child and Family connections throughout the state. The Bureau of Child Care and Development expanded mental health consultation for local service and childcare providers from four to nine pilot sites in FY'06. The School Health Centers are an important source of mental health counseling for the student bodies they serve. The IDHS is an active participant in IDPH's Suicide Prevention Task Force. The MCH program is an active participant in the Illinois Children's Mental Health Partnership. The Division of Community Health and Prevention and the Division of Mental Health continue to lead the Early Childhood mental Health State Plan Work Group. The work group created a charter, approved by IDHS leaders, that outlines their mission to examine the contribution IDHS makes in early childhood mental health; identify system gaps, challenges, and opportunities; determine the essential elements of a comprehensive, coordinated early childhood mental health system; and develop strategies to improve access to and quality of mental health services for 0 - 5-year-old children and their families.

//2008/ In FY'07 the Early Childhood Mental Health Consultant pilot expanded to 13 sites. All pilot programs received continuation funding through fiscal year 2008. //2008//

//2009/ The ICMHP has identified the following Strategic Priorities for enhancing Illinois' system of mental health treatment services for children: 1) Promote ongoing family/consumer and youth involvement in administrative, policymaking and resource decisions regarding the Illinois children's mental health system at the state, regional and local level; 2) Advocate for increased children's mental health services and programs; 3) Develop culturally competent mental health consultation initiative(s) that educate, support and assist providers in key child-serving systems (e.g., early childhood, child care, primary care, public health, mental health and education); 4) Create a comprehensive, culturally inclusive, and multi-faceted public awareness campaign plan; 5) Build public and private sector awareness and response to maternal depression with attention to prevention and early intervention efforts, and necessary follow-up assessment and treatment services, where appropriate; 6) Build and enhance school-based activities focused on social and emotional educational and support services, and provide professional development and technical assistance to school administrators and staff; 7) Promote mental health screening and assessment and appropriate follow-up services of children and youth involved in the child welfare and juvenile justice systems; 8) Increase early intervention and mental health treatment services

and supports for children: Ages 0-5 years; Transitioning out of public systems (e.g., child welfare, mental health, juvenile justice); Who have been exposed to or experienced childhood trauma (e.g., violence); Who need follow-up services in the SASS system beyond 90 days; and Who have mental health problems that are not severe enough to qualify them for public programs; 9) Convene a multi-agency and multidisciplinary work group to examine how children's residential mental health treatment services are funded and accessed in order to develop strategies for improving financing, cost-effectiveness, and access to residential services and alternative community services, where appropriate; and 10) Initiate development of a policy and research center(s) to support research-based workforce development, best practice models and technical assistance on children's mental health in such areas as cultural competence, family involvement and consumer-driven care. //2009//

Annual performance will be reported through the Block Grant application and annual report through National Performance Measure 16 and State Performance Measure 9.

Children with Special Health Care Needs

1. Improve access for CSHCN to quality healthcare through Medical Homes - This issue was identified by the CSHCN Advisory Panel and by families in both the national and the DSCC Family Surveys. This is also an area of special emphasis in the Healthy People 2010 goals for CSHCN.

/2010/ Building on the success of the Illinois Medical Home Project that was HRSA funded, ICAAP and DSCC are promoting a program called Building Community-based Medical Homes for Children funded by the Michael Reese Health Trust (3 year grant) and the Chicago Community Trust (1 year grant.) The program teaches how to set up effective medical home innovation teams; identify the patient population; include families in the QI process; make the practice accessible; make the practice family centered and culturally effective; provide planned, proactive care; develop written care plans for special needs patients; become a DSCC medical home provider and receive increased reimbursement; and participate in the National Committee for Quality Assurance's Physicians Practice Connection evaluation program.//2010//

2. Improve access for YSHCN to transition services - The complexity of transition issues for YSHCN was identified by the DSCC Family Surveys, (past and most recent), by respondents to the National Survey, and by the CSHCN Advisory Panel as particularly problematic for youth as they leave the services and supports provided to children.

3. The CSHCN Advisory Panel identified service linkage and coordination as an overarching concern. The DSCC Family Survey (past and most recent) demonstrated that families having children receiving SSI have significant problems in accessing needed services. DSCC is more effective in addressing these issues for families with children who are also enrolled in the DSCC program. DSCC continues to reach out to families whose children are not eligible to assist them in linking to appropriate programs and services in their local communities.

/2010/ See III. B. Children with Special Health Care Needs section for planned expansion of activities.//2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	99.5	99.9	99.6	99.7	99.8
Annual Indicator	99.9	99.9	99.8	99.2	99.2
Numerator	181975	178700	176890	175837	172256
Denominator	182158	178872	177234	177234	173565
Data Source					IDPH, Genetics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	99.9	99.9	99.9	99.9	99.9

Notes - 2008

Source: IDPH - Genetics. Denominator source: IDPH Center for Health Statistics - occurrent births.

Notes - 2007

Source: IDPH - Genetics. Denominator source: IDPH Center for Health Statistics - occurrent births.

Notes - 2006

Source: IDPH - Genetics. Denominator source: IDPH Center for Health Statistics - occurrent births.

a. Last Year's Accomplishments

More than 99 percent of the children born in Illinois were screened for over 30 metabolic disorders. Actual performance (99.2) was below the goal of 99.7 percent.

Each year, IDPH screens more than 175,000 newborns for over 30 conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, hemoglobinopathies, amino acid, organic acid, fatty acid oxidation disorders, and cystic fibrosis). Of these, more than 300 are diagnosed with one of these conditions, and another 4,100 are found to have an abnormal hemoglobin trait (refer to Form 6 in Appendix B). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling, and long term follow-up services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct hospital-based screening			X	
2. Laboratory results are reported to IDPH			X	
3. Parents and physicians are notified			X	
4. Local health departments are contacted when children can't be located for diagnostic testing			X	
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Newborns are routinely screened for more than 30 metabolic disorders. Infants with a positive screening result are followed through diagnostic evaluation, and children diagnosed for some conditions are followed up through 15 years of age.

Chicago. CDPH Maternal and Family Planning programs routinely screen for inherited disorders in community health clinics, and provide genetics education and referrals. In calendar year 2008, 2,198 clients were screened for genetic disorders, and 281 screened positive. All were referred for follow-up and further evaluation. The Public Health Nursing program receives referrals for children up to one year old for genetic disorders, and provides home visits and referrals to family counseling and genetics follow-up.

Folic acid is offered to all prenatal clients in an effort to reduce neural tube defects.

c. Plan for the Coming Year

The IDPH Genetics/Newborn Screening program will establish practices to ensure that every newborn in the state is screened. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder. A vendor, Pekin-Elmer, was selected to develop a web-based Newborn Metabolic Screening Data System that will have the capacity to interface with the birth record to ensure that all Illinois infants are screened.

Chicago. CDPH will continue routine genetic screening and referrals for genetics follow-up. It will continue to provide March of Dimes information on benefits of folic acid through a variety of venues, including churches, clinics, beauty shops, nail salons and grocery stores.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	60.6	60.6	60.6	60.8	60.3
Annual Indicator	60.6	60.6	60.6	60.3	60.3
Numerator					
Denominator					
Data Source					CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	60.3	60.5	60.5	60.7	60.7

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National CSHCN Survey found that 60.3% of families with CSHCN indicated that they are partners in decision making at all levels and are satisfied with the services they receive. This is only a slight decrease from the 2001 survey results.

DSCC developed a web-based tutorial on "Build your own Care Notebook" located on the AAP website. This tutorial is located at: www.medicalhomeinfo.org/tools/care_notebook.html. The tutorial was tested with members of the DSCC Family Advisory Council (FAC) with professionals and families in Chicago, and families across the country at the 2008 AMCHP conference in Washington DC.

The FAC met 3 times during the year and reviewed draft changes to the DSCC Family Handbook which is given to families during their enrollment period. The FAC also heard from a representative from HFS about proposed changes to the Home Care waiver program and provided input. DSCC provided a stipend and travel reimbursement for FAC members.

The Family Page on the DSCC website and the Special Addition family Newsletter kept interested families informed of MCHB and DSCC initiatives and other resources. DSCC continued to promote and support family participation in the Medical Home grant activities.

The DSCC Family Liaison assisted in the family support activities of the Newborn Hearing grant which included meeting with parent to parent support groups across the state to determine the availability of resources and mission of each group, identifying gaps in services to families of infants with hearing loss. The DSCC Family Liaison also participated in the DSCC Regional office staff training on Care Coordination teaming. Regional offices were re-organized to enhance care coordination activities.

The DSCC Family Liaison received the first Merle McPherson Leadership award from AMCHP for his family leadership at both the State and national level.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote family/CSHCN Program partnerships through the Family Advisory Council.				X
2. Promote family/physician partnership thorough the Medical Home initiative.				X
3. Family education on state/federal activities through Special Addition/DSCC Family website.				X
4. Collaboration with the Family-to-Family Health Information Center to improve access to information.		X		

5. Collaboration with families in Individualized Service Plan development.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FAC reviewed and provided input on the five national performance measures specific to CYSHCN during their meetings.

DSCC collaborated with the Illinois' Family-to-Family Health Information Center in addressing information and other resource needs identified by that project. The DSCC Family Liaison serves on the Family-to-Family Health Information Center advisory board.

DSCC continued to publish and mail the Special Addition Family newsletter to all enrolled families. The latest edition included only State information since the contract for receiving a National article expired.

The DSCC Family Liaison participated in the planning for the next Family Survey that is being sent to families who are currently receiving DSCC assistance and to families who only receive SSI services. He also participated in the DSCC workgroup that revised the forms for documenting the assessment and Individualized Service Plan for each eligible child. The draft forms were shared with the FAC members who provided favorable feedback.

c. Plan for the Coming Year

The Family Advisory Council (FAC) will continue to meet 3 times per year and explore ways to provide ongoing input into the Block Grant performance measure activities. The DSCC Family Liaison and the FAC chairperson will continue to explore ways to increase the cultural diversity of the DSCC Family Advisory Council membership.

The relationship with the Illinois' Family-to-Family Health Information Center and DSCC will continue next year. Statewide family leadership training will be a major emphasis for the Center with the DSCC Family Liaison participating in the training development and implementation phases. DSCC staff will continue to serve on the Family-to-Family Health Information Center advisory board and provide resource information and technical assistance as needed.

DSCC will be analyzing responses from our Family Survey. The DSCC Family Liaison will follow up with the families who request immediate contact.

The family newsletter, Special Addition, will continue to be published every six months and sent to DSCC families receiving services.

The DSCC Family Liaison will explore new ways of involving families regionally in new staff training activities where they will tell their stories about their experiences in receiving DSCC services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	50.7	50.7	50.7	50.9	45.1
Annual Indicator	50.7	50.7	50.7	45.1	45.1
Numerator					
Denominator					
Data Source					CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	45.3	45.3	45.5	45.5	45.7

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National Survey of Children with Special Health Care Needs found that 45.1% of CSHCN received coordinated, ongoing, comprehensive care within a medical home.

DSCC continued Phase II of the Illinois Medical Home Project (IMHP) MCHB grant evaluating the success or drawbacks of utilizing outside facilitators in primary care practices to structure quality improvement (QI). DSCC staff held training with representatives from Family Voices and Family to Family Health Information Centers on use of the Care Notebook online tutorial so they can begin facilitating family workshops on use of this tool. The Care Notebook tutorial was developed in coordination with the AAP National Medical Home Implementation website. DSCC continued facilitation of twelve Medical Home Quality Improvement Teams and provided technical assistance to another five teams. The 7-C Medical Home Practice Index and correlating Family Survey were tested with families and changes made based on input from families. Building upon the work initiated with the IMHP grant, DSCC collaborated with ICAAP to develop the proposal, Building Community Based Medical Homes for Children, which provides medical home quality improvement teams with facilitation support.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Integration of the Medical Home into care coordination that includes reimbursement.		X		
2. Medical Home physician training opportunities/Medical Home monograph				X
3. Statewide physician outreach.				X
4. Quality improvement technical assistance to physician practices				X
5. .				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Expansion of community resources for CYSHCN on the LifeSpan database is continuing. Phase II of the Illinois Medical Home Project grant ended in Sept. 2008. Overall, results for Phase II of the IMHP indicate that improvements have been made at each of the participating primary care sites. In most cases, sites that received facilitation support were more likely to hold monthly QI team meetings and follow through on implementing practice improvements. Teams with strong leadership accomplished many improvements regardless of which group they were assigned to (facilitated vs. technical assistance). The ICAAP proposal entitled Building Community Based Medical Homes for Children continues to secure funding for potential medical home expansion. The HRSA grant Reducing Loss to Follow-up in Newborn Hearing Screening has begun including efforts to promote medical home and link families to a medical home provider. DSCC is collaborating with The Autism Project (TAP) on a HRSA grant to enhance service capacity for persons with autism spectrum disorders and developmental disabilities and to expand and strengthen linkages in The Autism Program (TAP) Service Network. Access to the medical home model is emphasized and DSCC will be involved in training on the medical home model. Facilitation continues for ten Medical Home Quality Improvement teams with technical assistance provided to four teams.

c. Plan for the Coming Year

The medical home coloring contest will be repeated this year in partnership with Illinois Department of Human Services, Illinois Department of Healthcare and Family Services, and ICAAP. The winning drawings will be used to develop a 2010 calendar which will be shared with DSCC families, ICAAP primary care providers, IL Health Connect providers and with all participating school districts.

The 7-C Medical Home Practice and Family Surveys will be evaluated and tested for potential use in future medical home quality improvement projects. Statistical reliability and validity measures must be assessed. Building upon the work initiated with the IMHP grant, DSCC in partnership with ICAAP will begin recruiting practices to participate in Building Community Based Medical Homes for Children. DSCC will continue work initiated in the HRSA Universal Newborn Hearing Screening and Intervention grant by participating in the NICHQ Learning Collaborative to Reduce Loss to Follow-up in Newborn Screening. This grant activity includes promotion of family-centered care and linking families with their medical home provider. DSCC will continue to provide facilitation to eight medical home quality improvement teams.

DSCC collaborated with ICAAP on a proposal submitted for a MCHB State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs. Funding has been approved, so ICAAP and DSCC will begin enlisting involvement of state/community partners

to advance the medical home approach and enlist new practices to establish a medical home quality improvement team with a focus on health care transition planning. The project will implement a public relations plan to promote medical homes and host in-services for providers and families to spread implementation.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	53.3	53.3	53.3	53.5	59.3
Annual Indicator	53.3	53.3	53.3	59.3	59.3
Numerator					
Denominator					
Data Source					CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	59.5	59.5	59.7	59.7	59.9

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 CSHCN Survey found that 59.2 percent of Illinois families with CSHCN reported that they had adequate private and/or public insurance to pay for the services they need. This was a 5.9 percent increase from the previous CSHCN Survey.

DSCC care coordination teams assisted uninsured applicants and recipients to apply for the state All Kids Program. The All Kids and Medicaid program is intended to provide a public health insurance program for all children, including CYSCHN. All Kids is the state's integrated healthcare program for children, encompassing Medicaid, the State Children's Health Insurance Program (CHIP) and state only funded coverage for children regardless of income level, citizenship or immigration requirements of Medicaid. DSCC staff participated in Covering Kids

and Families Illinois meetings, which were a collaborative effort by stakeholders committed to adopting state policies and procedures to ensure family access to and retention in the All Kids/Family Care programs such as presumptive eligibility, one pay stub for income verification, on line applications and renewing eligibility administratively.

Approximately 5 percent of children enrolled in DSCC had no third party benefits during the last fiscal year. DSCC's benefits management technical assistance unit assists DSCC care coordination teams to maximize available funding resources for enrolled children. Benefits management staff trained new and experienced staff on benefits management, provided technical assistance to care coordination teams on public/private funding issues for individual CYSHCN, monitored federal and state legislation on public health insurance programs/private health insurance, provided outreach to other key agencies regarding program eligibility, and promoted awareness of funding issues and opportunities. Additional benefits management training occurred for realigned care coordination teams. The realignment increased the number of available staff to assist families with coordination of benefits.

DSCC assisted the Family to Family Health Information and Education Center (F2F) with development of a guide to Illinois and national internet resources for families with insurance issues. In addition, DSCC provided technical assistance to the F2F in the development of "A Guide for Families of Children with Special Health Care Needs, All Kids Insurance vs. COBRA Coverage Which One Should I Pick."

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Benefits management technical assistance team.		X		
2. Referral to All Kids		X		
3. Family benefits management resources/resource development		X		
4. Benefits management training for care coordination teams and families.		X		
5. Promote enrollment of uninsured CSHCN in All Kids		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DSCC, an application agent, continued to assist uninsured CYSHCN to apply to the All Kids and Medicaid Programs and other private and public programs available to pay for needed care. New and experienced staff continued to be trained on maximizing private and public funding sources for needed care. Benefits management staff continued to provide technical assistance to care coordination teams for individual CYSHCN, monitored legislation on public health insurance programs/private health insurance, outreach to other key agencies, and promoted awareness of health care funding issues and opportunities.

Illinois Comprehensive Health Insurance Plan (ICHIP) and the Department of Healthcare and Family Services worked on the potential development of health care expansion for those youth 19 years or older with chronic health conditions that lose All Kids eligibility. DSCC staff met with ICHIP program staff to discuss the DSCC eligibility determination process.

The Illinois Department of Healthcare and Family Services provided outreach to DSCC to educate care coordination teams regarding the state's Health Insurance Premium Payment

(HIPP) program eligibility and program benefits for CYSHCN. Care coordination staff assisted potentially eligible families to apply for the HIPP program, a program that pays an individual's share of the private group or individual insurance premium to maintain access and funding of health care.

c. Plan for the Coming Year

In February 2009, Illinois was one of eight states receiving the Robert Wood Johnson Foundation Grant to Maximize Enrollment and Retention for Kids in the All Kids. The grant was awarded to Department of Healthcare and Family Services. The goal of the Maximizing Enrollment for Kids grant is to ensure that there is "no wrong door" for families seeking health insurance for their uninsured children. DSCC will follow the grant activities and offer assistance in planning and developing strategies to address continued enrollment and retention of CYSHCN. DSCC care coordination staff will continue as All Kids Application Agents to enroll CYSHCN without insurance into the Medicaid, SCHIP and state health care expansion programs.

Collaboration will continue with partners from Family Voices and the F2F Grant in the development of and access to insurance information for families throughout the state. DSCC will continue to investigate and evaluate additional benefit management family support materials for families of CYSHCN. Contact information for the F2F will continue to be sent to all SSI eligible children, which includes assistance with health care and insurance questions.

New and experienced care coordination staff will continue to receive training on maximizing public and private funding sources for CYSHCN. Benefits management staff will provide technical assistance to care coordination teams for individual CYSHCN, monitor key legislation, outreach to other key agencies, and promote awareness of health care funding issues and opportunities

Recently passed state laws may provide additional funding resources for CYSHCN including: Insurance Coverage for Autism Spectrum Disorders, Adult Dependent Coverage and Habilitation Services for Children.

Care coordination teams will continue to discuss health insurance options with transition age youth and their families prior to the 18th birthday.

DSCC care coordination teams will continue to refer families to the state's Health Insurance Premium Payment (HIPP) program to ensure CYSHCN have access to private health insurance and assistance with premium costs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	76.1	76.1	76.1	76.3	89.8
Annual Indicator	76.1	76.1	76.1	89.8	89.8
Numerator					
Denominator					
Data Source					CHSCN SLAITS Survey

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	89.8	90	90	90.2	90.2

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National CSHCN Survey found that 89.8 percent of Illinois families with CSHCN reported that the community-based services systems were organized so that they can use them easily. This was a 13.7 percent increase from the previous CSHCN Survey.

DSCC staff coordinated and collaborated with state and local agencies to identify and resolve service gaps and duplication. Two DSCC staff provided consultation to the Family to Family Health Information and Education Center in Illinois and served on the Advisory Committee for the Center. Community system development efforts continued in all areas of the CSHCN Healthy People 2010 goals with emphasis on Medical Home, Transition, Newborn Hearing and Early Intervention. Please refer to NPM #3 for Medical Home activities, NPM #6 and SPM #2 for transition activities and NPM #12 for newborn hearing screening and follow up activities. DSCC continued to maintain an internet website to which information and links were added or updated regularly, including information on Medical Home, Transition and Newborn Hearing and a variety of resources. The website specifically about newborn hearing screening (www.illinoisoundbeginnings.org) has also been maintained.

Efforts to assist families of children eligible for SSI in accessing necessary services continued with telephone contacts attempted for children ages 3 to 4 years and 14 to 16 years. DSCC mailed information (in English and Spanish), providing resource information to families of children age 16 years or less that are newly eligible for SSI. DSCC's 800 number is also provided for families wanting assistance with accessing services.

DSCC staff provided care coordination to the families of 500+ children who are technology dependent/medically fragile (TD/MF) to facilitate access to needed services through a Home and Community Based Services (HCBS) Medicaid waiver so these children can live at home with their families in their communities. Efforts continued to facilitate the transition of these children as they approach 21 years of age and need to move to programs for adults. DSCC worked closely with HFS, the state Medicaid agency, and DHS-Division of Rehabilitation Services (DRS) and community agencies to address the needs of these children and young adults. The three-agency agreement addressing collaboration efforts for transition remained in effect.

HFS contracted with a vendor to develop an internet-accessible database for the data collected in the TD/MF waiver level of care (LOC), assessment and individualized service plan (ISP) for each child applying for that waiver. DSCC has been very involved in evaluating the functional aspects of the product.

Illinois' mechanism for families of individuals with developmental disabilities to make their needs known and help them access services, Prioritization of Urgency of Needs for Services (PUNS), was used by DHS' Division of Developmental Disabilities to identify and provide services to children and adults most in need. DSCC care coordination staff informed families about the benefits of completing a PUNS assessment and referred families to the intake entities in their area.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care coordination infrastructure for eligible families.		X		
2. Collaborative memorandum of understanding with agencies				X
3. Mutual referral process with the Early Interention Program.				X
4. Collaborative efforts with the state transition effort.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DSCC and HFS are working with the vendor on contract with HFS to develop an internet database for the LOC, assessment, and ISP data for children in the TD/MF waiver. The database will enable DSCC and HFS to access data and conduct necessary analyses.

DSCC staff assist families with no insurance to apply for All Kids. DSCC works to assure that DSCC children, all of whom are exempt from the Medicaid Primary Care Case Management (PCCM) program, are identified in the Medicaid and PCCM databases, so that these children can be disenrolled from that program and its requirements. DSCC provided a supply of DSCC Medical Home calendars to the PCCM contractor for primary care physicians to increase awareness of DSCC and Medical Homes. DSCC care coordinators assist all families with children enrolled in DSCC, including those in All Kids, to access primary and specialty health care services.

Efforts to improve systems of services continue in the areas of Medical Homes, Transition, Newborn Hearing and Early Intervention. These are discussed in other performance measures.

DSCC provides information to children newly eligible for SSI with phone calls attempted to families with children ages 3-4 years and 14-16 years to assist them in linking to appropriate services.

DSCC collaborated with ICAAP to submit a proposal for the State Implementation Grants for Systems of Services for CYSHCN. The proposal emphasizes medical home, transition and other system components.

c. Plan for the Coming Year

DSCC will continue collaborative efforts with HFS and DHS-DRS to improve the transition of children from the TD/MF Medicaid waiver as they reach 21 years of age to other appropriate programs and services. HFS and DSCC will continue developing quality management strategies that link to outcomes and provide data to assist with making system wide improvements in the overall quality of services for all children. Efforts to improve systems of services for CSHCN will continue, especially in the areas of Medical Homes, Transition, Newborn Hearing and Early Intervention. DSCC will produce and disseminate a calendar again next year to promote care coordination and Medical Homes.

DSCC will continue collaborative efforts with ICAAP on the HRSA integrated systems grant that was recently approved for funding. This grant will improve the ability of PCPs to incorporate principles of the medical home model into their practices and better link families with community-based services and create inclusive community-based systems of services for CYSHCN through a collaboration of statewide stakeholders. ICAAP will establish a subcontract with the Illinois Family-to-Family Health Information and Education Center to ensure outreach to families and provide training to families on medical home and transition. The Arc of Illinois will also be subcontracted to enhance their database of services to improve medical home provider and family access to information on services in their communities.

DSCC staff will continue to assist families needing support services for their children with developmental disabilities, including referral to PUNS. DSCC will also continue to assist families having children age 16 years or less, newly eligible for SSI, to connect with needed services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.8	5.8	5.8	5.9	44.2
Annual Indicator	5.8	5.8	5.8	44.2	44.2
Numerator					
Denominator					
Data Source					CHSCN SLAITS Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	44.2	44.4	44.5	44.6	44.6

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National CSHCN Survey found that 44.2 percent of Illinois youth and their families received the services necessary to make transition to all aspects of adult life. This data is not comparable to the previous CSHCN Survey.

The Interagency Coordinating Council (ICC) on Transition's commitment was reflected in the development of work groups to implement the Strategic Plan that guides work with policymakers and practitioners to provide information, consultation and technical assistance to state and local stakeholders. Another Council commitment was community service reform/enhancement strategies that impact Illinois. Additional accomplishments included promoting awareness and participation of agency directors relative to ICC priorities, by sending a letter to each agency director requesting re-commitment to ICC, identification of designees and financial and in-kind resources to support ICC's operations. To increase collaboration, member agencies provided updates at meetings, resulting in co-promotion of events and greater cross-agency participation. The ICC strategized on improving policy and legislative support through development of a legislative liaison. The ICC met annually with the Illinois State Advisory Council on the Education of Children with Disabilities (ISAC). To insure on-going dialogue and collaboration, a liaison from each Council is represented on the other.

DSCC participated on the steering committee and subcommittees for the third statewide transition conference, Beyond Expectations: Time for Change, December 2007. Over 730 participants attended the conference. The health care transition track was expanded to two conference days targeting health care providers, families and youth. Experts in transition for youth with chronic health conditions/disabilities presented. Keynote speakers included Dr. Diane Straub, Director of Teen Health at the University of Florida and Janet Hess from the University of South Florida presenting on What's Health Got to Do with Transition? A Multi Level Health Care Transition Education Program attended by educators, school administrators, vocational specialists, community partners, advocates, transition specialists, care coordinators, health care providers, families and youth. Breakouts were presented by Ronna Linroth from Minnesota's Gillette Children's Specialty Healthcare and Dr. Shubhra Mukherjee from Children's Memorial Hospital and the Rehabilitation Institute of Chicago. Thirty-seven health care providers participated.

Patience White MD presented on health care transition at the Illinois' Medical Home Learning Collaborative in December 2007.

Regional Transition Planning Consortia provided networking opportunities, improved collaboration and statewide information resource sharing.

The University of Illinois at Chicago Department of Disability and Human Development Rehabilitation Research Training Center on Aging with Developmental Disabilities (RRTCADD) in collaboration with DSCC successfully implemented a one-year grant project, Building Capacity

among Pediatric Residents to Promote Health Advocacy among Persons with Developmental Disabilities. The project, funded by the Illinois Council on Developmental Disabilities, aimed to increase understanding of the health care experiences and the needs of adolescents with developmental disabilities (DD) among pediatric residents. Health advocacy workshops were provided to pediatric residents to increase knowledge, improve attitudes and enhance self-efficacy towards health advocacy for adolescents with disabilities. The project targeted residents in seven Illinois Pediatric Residency Programs. Ninety-seven health professionals, including 67 pediatric residents, 3 medical students, 1 fellow, and 25 other health professionals (rotation directors, nurses and others) received the two hour training. The training included four modules: 1) observe good models of communication with pediatric patients with DD/SHCN and their families; 2) learn to promote physical activity, healthy food choices and other preventive measures to decrease co-morbidities; 3) promote building self advocacy skills with patients and improve health literacy; and 4) increase awareness of available community resources to meet the needs of adolescents/young adults with DD/SHCN. The curriculum is available through the RRTCADD so that training can be conducted by faculty at each Pediatric Residency Program as a model program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participation on the Illinois Interagency Coordinating Council for Transition.				X
2. Transition training/technical assistance for care coordinators.		X		
3. Expansion of state data collection mechanisms.				X
4. Promoting awareness of transition issues/resources.				X
5. Participation in Annual Statewide Transition Conference planning group.				X
6. Expansion of partnerships and alliances.				X
7.				
8.				
9.				
10.				

b. Current Activities

DSCC continued participation on the Illinois Statewide Transition Conference Steering Committee for this year's conference on October 27-29, 2008 in Peoria, IL. The health care track provided information and training to adult healthcare providers and other stakeholders on healthcare transition; increasing collaboration with transition partners to improve and sustain systems of care; and improving access to high quality, developmentally appropriate healthcare.

DSCC continues to increase community-based collaboration that is committed to developing a high-quality, well-coordinated, easily-accessible system of care within medical homes for young people with special health care needs around transition issues. DSCC has scheduled presentations on transition for two of the Illinois Medical Home Quality Improvement Teams. Planning and collaboration continues in an effort to prepare for the HRSA State Implementation Grants for Integrated Community Systems for Children and Youth with Special Health Care Needs.

c. Plan for the Coming Year

Ongoing trainings for health care professionals, youth and families will be provided through the Annual Statewide Transition Conference and the Annual Illinois Youth with Disabilities Leadership Summit. ICAAP will again obtain continuing medical education credits for physicians and will promote the conferences in their mailings to members. Children's Memorial Hospital in Chicago will be involved in conference planning and outreach. DSCC will continue to participate on state and local councils/committees to promote collaboration with external transition partners. The Illinois ICC and State Advisory Council on the Education of Children with Disabilities will continue collaborating on transition issues that may require legislation.

The ICAAP proposal for the HRSA State Implementation Grants for Integrated Community Systems for Children and Youth with Special Health Care Needs was approved for funding. DSCC will have a greater opportunity to increase collaboration with partnering organizations, provide additional trainings, and support youth with special health care needs to transition into the adult healthcare system and maximize their potential in adulthood. Training and support will be provided to health care providers and families to assist youth transitioning into the adult healthcare system and maximize their potential in adulthood. Four pilot sites will participate in a Learning Collaborative to share lessons learned working with transitioning YSHCN, develop a transition toolkit and test it, and develop a transition training module for pediatric and adult primary care providers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	82	84.5	85	87	79
Annual Indicator	83.7	84.8	81.9	78.5	79.5
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	81	81	82	85	85

Notes - 2008

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Provisional data during preparation of this application is available for Q3-2007 to Q2-2008. This report does not provide a numerator or denominator. The data are derived from a telephone interview of approximately 400 individuals.

Notes - 2007

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Provisional data during preparation of this application is available for Q3-Q2. This report does not provide a numerator or denominator. The data are derived from a telephone interview of approximately 400 individuals.

The trend appears to be decreasing. However, the Confidence Interval for the percent coverage with 4:3:1:3 is +/- 6.8 suggesting that the decrease is not statistically significant. (2007 data caused a "Data Alert" or a departure from past performance with administering these immunization series.)

Notes - 2006

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age - National Immunization Survey. Final data for a given year includes Q1-Q4, 2006. This report does not provide a numerator or denominator.

a. Last Year's Accomplishments

The most current release of the National Immunization Survey (NIS) results in 2008 indicates that series completion levels for Illinois are as follows: 4/3/1/3/3 series at 78.9 percent; 4/3/1/3/3/1 series reported at 77.5 percent. The NIS data for the Illinois federal project area that excludes the city of Chicago are as follows: 4/3/1/3/3 series at 80 percent and the 4/3/1/3 series at 79.5 percent. These series levels track additional vaccines that have been included on the ACIP recommended childhood immunization schedule.

IDHS, IDPH, and IDHFS have collaborated on a campaign to improve the immunization level of children participating in the WIC program. Local WIC agencies (most of which are local health departments) received regular reports from IDHS on the proportion of infants and toddlers in the WIC program who were fully immunized. In addition, IDPH provides funding to support immunization efforts in CEDA WIC agencies. During 2008, 85.7 percent of children ages 12 - 18 months served at one of 15 CEDA-operated sites met the 3/2/2 coverage and 83 percent of children ages 24-35 months met the 4/3/3/1 series coverage. Statewide, WIC children ages 12-18 months achieved 3/2/2 series coverage of 84.6 percent. This is an increase from the previous reporting period. Levels for 4/3/3/1 at 24-35 months of age remained stable at 77.6 percent.

IDPH provides federal immunization grant funds to support Vaccines for Children Assessment, Feedback, Incentives and Exchanges (VFC-AFIX) and provider education initiatives through the Illinois Chapter of the American Academy of Pediatrics (ICAAP), Rockford Health Council, CCDPH, Will County Health Department, Macon County Health Department, Madison County Health Department, and Peoria City-County Health Department. In 2008, St. Clair County Health Department also received supplemental funding to support these efforts. VFC operations require that a minimum of 25 percent of all enrolled providers receive a site visit annually. There are over 1,748 VFC enrolled provider sites (excluding Chicago) representing over 3,000 physicians. During 2008, the Illinois project area (excluding Chicago) conducted 587 site visits representing 34 percent of enrolled sites.

In addition, general revenue funds have been awarded annually since FY01 to four agencies providing direct services to children in areas identified as high risk to under immunization or access to healthcare services as well as areas with identified health care disparities.

Chicago. Chicago's immunization rates remain below the national average and below the national goal of 80 percent for the 4/3/1/3/3/1 childhood series. As new antigens have been introduced, the uptake in Chicago has been strong and comparable to other states nationally. What continues to challenge the city's series completion rates is the 4th DTap vaccination.

The CDPH provides federal funds to St. Bernard Hospital to operate the Baby Immunization Tracking System (BITS), which is designed to track infants born at the hospital through their first years of life or until their shots are up-to-date. In 2008, 1,062 children were born at the hospital

and 100 percent received their "birth dose" Hepatitis B vaccine before they were discharged.

CDPH's immunization Program operates nine walk-in immunization clinics that served over 5,014 children in 2008. For FY2007, 88.6 percent of two-year-olds were fully immunized in CDPH's Family Case Management, Public Health Nursing and community health clinics, an increase over 87.1 percent for FY2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The IDPH Immunization program distributes vaccines to local health departments and Vaccines for Children			X	
2. The IDPH Immunization program assesses immunization levels of children served in public clinics				X
3. The IDPH Immunization program directs additional resources to areas identified as "Pockets of Need."			X	
4. Additional outreach activities are conducted by the Chicago Department of Public Health & community organizations or coalitions			X	
5. IDHS monitors and distributes reports of immunization coverage of children in the WIC program				X
6. IDHS monitors immunization coverage of children in programs for infants, young children, and teen parents		X		
7. IDHFS sends reminder notices to families		X		
8. IDHFS collaborates with IDPH on Vaccines for Children				X
9. IDHFS included childhood immunizations (by age 2) as a bonus payment strategy within the managed care program (MCO and PCCM). The measure of childhood immunization by 24 months in addition to immunization by 36 months will also be added.				X
10. IDHFS provides patient-specific feedback on immunization status to Primary Care Case Managers				X

b. Current Activities

The IDPH Immunization program is federally funded and is authorized by Section 317 of the Public Health Service Act. Additional federal funds are awarded annually through the federal Vaccines for Children (VFC) program as established through OBRA93. The program operates the following: 1) distributes vaccines to public and private providers statewide; 2) conducts surveillance and investigates outbreaks of preventable childhood and adult diseases; 3) conducts mandatory assessments of vaccine coverage levels among various target populations; and 4) works with the IDHFS to improve immunization levels among Medicaid-eligible children.

Chicago. CDPH supports "Keeping Immunizations Current for Kids" (KICK), which is a provider-based reminder and recall program. The KICK program is designed to increase immunization rates among African American and other minority children between the ages of 0-5 through a coordinated reminder/recall and outreach program. The Immunization Program operates nine immunization walk-in clinics that provide fast, free and friendly immunization services to children 0-18 years of age. The nine Fast Track clinics are located in seven community areas.

c. Plan for the Coming Year

IDHS, IDPH, and IDHFS will continue the WIC Immunization campaign. Immunization records will be added regularly to the Cornerstone and ICARE systems from the Medicaid Management

Information System and the immunization tracking software used by the Chicago and Cook County Health Departments.

Quarterly reports on the immunization coverage of one and two-year-olds will be provided to local WIC agencies. The information will be followed up with consultation and technical assistance from regional staff.

IDPH will continue the following assessment activities:

Conduct and review the annual IDCFS/IDPH child care and Head Start survey through a random selection method developed by CDC. (A separate survey is conducted the Chicago Department of Public Health. Results are provided to IDPH). The program will also work with the Child Care Resource and Referral Networks to educate child care facility staff regarding implementation and enforcement of immunization requirements. The survey has been revised to aid completion, improve compliance, and meet CDC reporting needs.

Conduct visits at a minimum of 25 percent of enrolled provider sites with VFC to determine VFC compliance and conduct assessment of practice coverage levels.

Continue the annual quality assurance reviews to determine compliance with the Standards for Pediatric Immunization Practices. The reviews have proven to be successful in identifying existing barriers and documenting recommendations for improvements in clinic practices. Documentation required to comply with the National Childhood Vaccine Injury Act is reviewed thoroughly. Quality assurance reviews will use the AFIX strategy as developed by CDC. IDPH has a grant agreement with the ICAAP to extend AFIX services and conduct peer provider education according to a curriculum developed entitled "Reaching Our Goals". This peer education strategy will also promote "birth dose" Hepatitis B vaccine efforts as well as adolescent immunization services and promotion. Additional grant agreements with local health departments have been established to support AFIX activities in counties/regions with high volume of enrolled provider sites.

Chicago. The CDPH Immunization Program will continue to intensify strategies to improve immunization rates in Chicago with the following current activities: outreach, FastTrack clinics, the CareVan, the WIC Immunization linkage program, and partnership with St. Bernard Hospital. CDPH's Public Health Nursing, Family Case Management, Healthy Start and the community health clinics will continue to track immunization status of two-year-olds and provide immunizations as necessary.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	23	22	21	21	21
Annual Indicator	22.8	21.2	22.1	22.1	22
Numerator	5983	5794	6120	5988	
Denominator	262266	273565	276507	270929	
Data Source					IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	21	21	21	21	21

Notes - 2008

Vital Records data for births in 2008 are not available at this time. 2007 data is being used as provisional at this time.

Notes - 2007

Source: IDPH Birth for 2007, received May 2009.

Notes - 2006

Source: IDPH Birth for 2006, received August 2008.

a. Last Year's Accomplishments

The rate of births to 15 to 17 year-old women in 2007 was 22.1 per 1,000; the same rate reported in 2006 (22.1 per 1,000) and above Illinois' performance target (21 per 1,000). The birth rate among 15 to 17year-olds has declined by 18 percent between 2000 and 2005. The birth rate has increased among whites (3 percent) and blacks (4 percent); and decreased by 1 percent in Hispanics. These are the most recent data available.

The number of births to teen mothers dropped below the record low set in 2003 by 128 births. Several programs in the Division of Community Health and Prevention work to prevent teen births, including:

- The Primary and Subsequent Teen Pregnancy Prevention programs provided services to 66,000 (Subsequent pregnancy served 414 teens)adolescents in SFY'08;
- Teen Parent Services helped more than 2,448 low-income teen parents work on finishing school and move from welfare to work in SFY'08;
- Parents Too Soon helped more than 2,101 teen parents develop parenting skills, delay a subsequent pregnancy, and finish school.
- The Family Planning Program provided comprehensive reproductive health services to 33,658 adolescents in CY' 08.
- Teen Pregnancy Prevention -- Primary Program delivered comprehensive sex education services to 64,064 teens and parents in SFY' 07.
- Abstinence Education Program reached 62,184 unduplicated youth and 2,771 parents through abstinence and life skills education, peer programs, out-of-school positive youth development activities and parent education services in SFY'07.

This comprehensive array of services includes widely recognized best practices for helping teens make healthy choices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. IDHS awards grants for Primary Teen Pregnancy Prevention programs		X		
2. IDHS awards grants for Subsequent Teen Pregnancy Prevention programs		X		

3. IDHS monitors repeat pregnancy rates among the clients of programs that serve teen parents				X
4. IDHS awards grants for Family Planning programs	X			
5. IDHS awards grants for Abstinence-only education programs		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Primary and Secondary Prevention of teen pregnancy and sexual activity before marriage is being addressed by the routine activities of the Abstinence Only Education, PTS, TPS, TPP, SHCs, School Health, and Family Planning programs. School Health Centers conduct risk assessment of all regular clinic users and provide anticipatory guidance, treatment or referral for sexual health and contraceptive services are included.

Chicago. Through its Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, and Male Responsibility programs CDPH continues to assure that services are provided so that initial and repeat pregnancies are prevented. The Male Involvement and Family Planning programs provide education to teens on abstinence, safe sex practices to avoid unintended pregnancy and sexually transmitted infections including HIV, contraception, the prevention of sexual coercion, domestic violence, pre/interconception care including nutrition, exercise, and avoidance of smoking, alcohol, and drug use.

Chicago Public Schools use various curricula for their sex education program, including those from Planned Parenthood and those that have an abstinence-only focus.

c. Plan for the Coming Year

Prevention of teen pregnancy and sexual activity before marriage will be addressed by the routine activities of the PTS, TPS, TPP, SHCs, School Health, and Family Planning programs.

Chicago. CDPH will continue to address adolescent pregnancy through Family Case Management, Public Health Nursing, outreach, Family Planning, Healthy Start, and Male Responsibility programs. The Chicago Public Schools will continue to work with youth leaders and the Illinois Caucus for Adolescent Health to continue to implement and improve their sex education curriculum,

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	9.5	27	27	27	28
Annual Indicator	27.0	27.0	27.0	27.0	27.0
Numerator	42219	42219	42000	42000	42000
Denominator	156370	156370	155356	155356	155356

Data Source					IDPH, Oral Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	28	28	28	28	28

Notes - 2008

According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is in progress for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. The very small underresourced public health program completes a statewide third grade Basic Screening Survey every five years based on the Association of State and Territorial Dental Directors and CDC guidance.

Notes - 2007

According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is planned for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. It is possible in the future that Illinois will have a more positive method of reporting these data as a state instead of relying on the data collection of a very small underresourced public health program.

Notes - 2006

According to the IDPH, Oral Health program, the next oral health state level 3rd grade survey is planned for 2008-09. The 2004 through 2007 percentage is from its 2003-04 oral health survey results. Every year the MCH program has extrapolated this percentage to the statewide population of 3rd grade students located at the Illinois State Board of Education's website. Since the percentage has not changed, the MCH program is reporting last year's numerator and denominator.

The annual performance objectives for 2008-2012 have been adjusted one percent to correct a 'data alert' stating the state has already surpassed subsequent year's objectives. This has been true since 2005. It is possible in the future that Illinois will have a more positive method of reporting these data as a state instead of relying on the data collection of a very small underresourced public health program.

Source for this estimate: Fall Housing, 2006-2007 District Summary, State Total of Grade 3 Students. Illinois State Board of Education website. The numerator has been adjusted to reflect the last reported percent by IDPH in 2004.

a. Last Year's Accomplishments

Illinois revised its goal of increasing the proportion of third-grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 27 percent.

In school year 2003-2004, the IDPH Division of Oral Health (DOH) completed a basic screening survey of third grade children. The Healthy Smiles/Healthy Growth survey obtained important information about caries history (whether or not a child had evidence of any prior cavities), current untreated cavities, treatment urgency, presence of sealants, demographics, and socioeconomic variables. The survey found that 27 percent of all third graders had at least one dental sealant. The rate in the City of Chicago was 12 percent. In a 1993-1994 survey, 13 percent of third graders statewide and 3 percent in the City of Chicago had at least one sealant.

This performance measure is addressed by the IDPH Dental Sealant Grant program. Retention rates, monthly and quarterly reports, and on-site reviews are utilized to evaluate program performance. Communities are responsible for developing protocols for their programs in order to assure proper infection control, retention rates, equipment maintenance, patient referral and follow-up and adequate procedures for assuring eligibility.

The Chicago Department of Public Health Dental Sealant Program was initiated in 2000 and is growing steadily each year. During the school year 2007-2008, the School Based Dental Program performed oral health services on approximately 66,000 children and placed approximately 200,000 sealants. Services were provided in 540 Chicago Public Schools. Target grades were increased to include all grades. The program is using a data system using scannable forms to aid their reporting process to the Chicago Public School (CPS) system and to the ISBE.

The Dental Sealant Grant Program completed an evaluation of the sealant program based on CDC's Program Evaluation Guide. The evaluation documented achievement of programmatic objectives, accomplishment of planned activities, and the quality of care provided through the program. Based on the evaluation of the program's data needs and collection process, the Division of Oral Health offers sealant program data software to community programs. DOH trained 12 grantee communities to collect data electronically that provides program management and evaluation including an assessment of program cost effectiveness and averted disease rates.

The community programs provided school dental examinations as an adjunct to the program in order to assure their schools and the children they serve are compliant with the new school dental examination statute in Illinois. The mandate requires all children in Kindergarten, second, and sixth grades to show proof of a dental examination. The first three years of data (2005-2008) demonstrated excellent compliance rates. In 2007, schools began to report oral health status information that may prove to be a valuable source of community specific data.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH works with local health departments and schools to conduct dental sealant grant programs	X			
2. IDHFS contracts with Doral Dental to monitor sealant levels and conduct targeted outreach				X

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH has 60 dental sealant program grantees throughout the state that provide oral healthcare, oral health education, dental examinations, referrals for needed treatment, and outreach for All Kids enrollment. The Division of Oral Health is providing technical assistance and training on a new dental sealant data system, SEALs for 12 community programs. The data system monitors their program performance and provides monthly reports to the Division of Oral Health electronically, easing the amount of paperwork involved in the program. SEALs will be a source of oral health status data as it collects DMFTS information on every participating child.

The Division is working with the Illinois Department of Healthcare and Family Services to enhance the sealant program referral process using the Medicaid Administrator, Doral of Illinois, to contact families with children identified through the sealant program as needing dental treatment.

Chicago.

The Chicago Department of Public Health School-based Dental Sealant Program Quality Assurance Program continues to review the work of oral health care providers. The sealant retention rate was well over the 90 percent required by the State. The Chicago program has installed a data system using scannable forms that will aid their reporting process to IDPH, the Chicago Public School System and the Illinois State Board of Education.

c. Plan for the Coming Year

The Division will continue to evaluate the use of the CDC's SEALs reporting software and to collect electronic data from additional grantees using other dental program data systems such as Dentrix. The program will continue to work with HFS to monitor and assure case management/referral and the quality of oral health care provided in school-based programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	2.6	2.4	2.4	2.4	2
Annual Indicator	2.4	2.0	2.2	2.0	2.0
Numerator	64	55	58	54	54
Denominator	2699740	2752100	2640114	2643433	2643433
Data Source					IDPH and IDOT
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	1.9	1.9	1.8	1.8	1.8

Notes - 2008

Vital Records data for deaths for 2007 or 2008 are not available at this time. Refer to the general Form 11 Note.

Notes - 2007

Vital Records data for deaths for 2007 or 2008 are not available at this time. Refer to the general Form 11 Note.

IDOT has posted their 2007 Annual Report at their website containing the number of deaths by age. Even though this is a final report, IDPH remains the final source for number of deaths.

Notes - 2006

Source: IDPH - Vital Records data for deaths - 2006.

a. Last Year's Accomplishments

Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2.0 per 100,000 children. Actual performance was 2.0 per 100,000 in 2008, the most recent data available.

The Department continued its partnership with the city of Chicago Police Department, the Illinois State Police, local hospitals and health centers, and the IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and over 3,000 car seats were checked for proper seat installation. During a car seat check we show clients how to properly use seat belts as well as proper car seat installation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1.IDHS conducts child safety seat checks. /2008/ Change to read: IDHS participates in child safety seat checks and seat distribution. //2008//		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Due to a lack of funds, the Department has significantly reduced the distribution of car safety seats.

c. Plan for the Coming Year

The Department will expand the number of Child Safety Seat checks statewide. The Department and the Illinois State Police, along with a network of health departments, community-based organizations, DHS local offices, and churches will conduct child safety seat checks and distribute child safety seats in the coming year. Use of child safety seats is a community issue. Many parents cannot afford to purchase a child safety seat or properly install the safety seat. The Child Passenger Protection Act was established to protect the health and safety of children through the proper use of "approved child safety restraint system.

Healthy Child Care Illinois provides families and child care providers with educational support and resource referrals on transportation safety to include the importance of child safety seats.

All students enrolled in school health centers are assessed for risk of unintentional injury and provided with health education focused on injury prevention, bicycle safety, and seat belt use.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			31	28	26
Annual Indicator		30.0	28.0	25.7	25.7
Numerator		16187	15328	14483	15193
Denominator		53960	54663	56315	59219
Data Source					IDHS, State Breastfeeding Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	27	27	28	28	28

Notes - 2008

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2008 Annual Report, CHP, IDHS. According to the Breastfeeding Report Card, United States 2008: Outcome Indicators (which reports WIC and Other data) the Illinois' percent at 'breastfed at 6 months' was 37.5.

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first

assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years.

Notes - 2007

The Numerator is infants Still Breastfed at 6 Months. The Denominator is infants Ever Breastfed. Source: Count and Percent of WIC Breastfed Infants, SFY 2007 Annual Report, CHP, IDHS. According to the Breastfeeding Report Card, United States 2007: Outcome Indicators (which reports WIC and Other data) the Illinois' percent at 'breastfed at 6 months' was 40.9.

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years.

Notes - 2006

The downward trend is due to stricter edits or quality assurances measures added to the client information system. Previously, WIC service providers reported breast feeding at the first assessment (newborn) and did not update that information upon subsequent visits. The information system now requires an update with every certification/assessment visit. The reported information more accurately reflects breast feeding behavior at six months than in previous years

Source: Count and Percent of WIC Breastfed Infants, SFY 2006 Annual Report, CHP, IDHS.

a. Last Year's Accomplishments

In 2008, 25.7 percent of WIC participants continued breastfeeding for six months. From the 2008 CDC Breastfeeding Report Card, United States -- 2008: Outcome Indicators, all Illinois women had a 37.5 percent breastfeeding rate at six months. Illinois collects data on breastfeeding practices through the Cornerstone Information System for CDC Nutrition Surveillance Systems and internal and external use in identifying breastfeeding patterns and practices. These include: initiation and duration of breastfeeding, exclusivity, client contacts, and breast pump issuance.

To promote and support extended breastfeeding among the WIC population, DHS has provided technical assistance and consultation on breastfeeding promotion, support and management for health departments and other local agencies administering WIC and other MCH programs statewide. Through regional and statewide training, staff are kept up-to-date with advances in breastfeeding research. Over 500 staff and community partners attended the two-day State Breastfeeding Conference last year. Additionally, over 298 staff participated in three Advanced Breastfeeding trainings. Seventy-five staff attended week-long intensive breastfeeding trainings that resulted in certification as a Certified Lactation Counselor or Breastfeeding Support Counselor. Three Bridges to Breastfeeding workshops were held in central, southern and northern Illinois. Bridges to Breastfeeding is a new initiative focusing on community collaboration to help Illinois reach the Healthy People 2010 breastfeeding goals. Designed and developed by well-known breastfeeding experts Jan Barger, RN, MA, IBCLC and Carole Peterson, MS, IBCLC, the program brings together local hospital and health department staff around the issues of breastfeeding education and support. Three hundred and forty staff were trained through these three workshops.

IDHS collaborates with the Illinois Department of Public Health, Division of Chronic Disease Prevention & Control, Office of Health, Nutrition, Physical Activity and Obesity Program to develop strategies to increase awareness of breastfeeding's role in preventing obesity. IDHS has

worked together with IDPH to develop and implement the Grandmothers Tea project. Through this activity, grandmothers learn up-to-date breastfeeding information as well as ways to support breastfeeding women. .

Chicago/local agencies: CDPH held its 3rd annual "Breastfeeding Promotion Walk and Celebration Day" at Rainbow Park & Beach. Over 800 participants, including men, women, grandparents, children and infants from all racial and ethnic groups attended and rallied their support for breastfeeding. Dr. Terry Mason, Commissioner of the Chicago Department of Public Health led the walk and encouraged breastfeeding for all families "Building a healthier Chicago starts with building healthier babies and building healthier babies starts with breastfeeding."

Numerous breastfeeding and child health advocacy organizations participated with CDPH and helped make this event successful, including: Healthy Families, March of Dimes, SIDs of Illinois, Chicago Breastfeeding Task Force, LaLeche League, Ameda and Medela. Vendors and supporters provided live entertainment, lunch, healthy snacks, and take home items that included breastfeeding literature, tee shirts, book bags, school supplies and raffle gifts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS promotes breastfeeding through the WIC program		X		
2. IDHS provides technical assistance and consultation on breastfeeding promotion for local WIC providers				X
3. IDHS increases the grant awards of local WIC agencies that excel in breastfeeding initiation and duration				X
4. IDHS distributes promotional items for World Breastfeeding Week and Illinois Breastfeeding Month				X
5. IDHS conducts training programs for breastfeeding coordinators in local WIC programs				X
6. IDHS supports the activities of state and regional breastfeeding task forces				X
7. IDHS oversees a breast pump program		X		
8. IDHS provides breastfeeding education to the local staff of other MCH programs		X		
9. IDHS collects information for CDC's Prenatal and Pediatric Nutrition Surveillance Systems through Cornerstone				X
10. IDHS is taking the lead in drafting a "Breastfeeding Blueprint for Illinois"		X		

b. Current Activities

Illinois Breastfeeding Promotion and Support Month will be celebrated in August, coinciding with International World Breastfeeding Week. The theme "Breastfeeding: A Vital Emergency Response" will be the focus of annual celebrations and events focusing on breastfeeding.

DHS continues to support the activities of local agency Breastfeeding Coordinator statewide through technical assistance and educational materials. Breastfeeding program updates are provided on a regular basis through regional meetings and a bi-monthly newsletter.

IDHS provides technical assistance and consultation to local agencies with Peer Counselor programs and other special breastfeeding projects. Forty agencies provide Peer Counselor services to eligible participants. Over 80 Peer Counselors provide education and support to eligible participants. In FY08, 36.0 percent of the women who received Peer Counselor services continued breastfeeding at six months..

Chicago. CDPH is leading a citywide celebration in recognition of the importance of breastfeeding in the health of Chicago's children, the 4th annual Breastfeeding Awareness Walk and Celebration, August, 2009. Eleven CDPH WIC, FCM, and Public Health Nursing (PHN) staff recently completed the certified lactation counselors, bringing to over forty the number of staff with advanced breastfeeding education. Most WIC sites have a designated breast-feeding room, furnished and decorated in a comfortable and welcoming manner.

c. Plan for the Coming Year

The Loving Support Breastfeeding Peer Counselor Program continues to expand. Additional resources are allocated for improving existing programs and implementing new programs. Five new start-up Peer Counselor programs will be implemented.

IDHS continues to collaborate with the Illinois Department of Public Health, Division of Chronic Disease Prevention & Control, Office of Health, Nutrition, Physical Activity and Obesity Program to develop strategies to increase awareness of breastfeeding's role in preventing obesity and to develop additional strategies to promote and support breastfeeding. Upcoming projects include: encouraging Baby Friendly policies at local WIC agencies and area hospitals, expanding the Bridges to Breastfeeding Program, collaborating with an area hospital to establish a milk bank and developing a database of businesses in Illinois that provide lactation services.

Plans are underway to provide targeted regional workshops designed to standardize breastfeeding information and foster better working relationships between providers and hospitals. Three additional Bridges programs will be held in FY10. To support the implementation of the new breastfeeding food packages, ten staff will attend the USDA sponsored Train-the-trainer course "Loving Support: Building Breastfeeding Competencies for Local WIC Staff". The competency-based breastfeeding training will then be provided to all local WIC staff.

Through the Illinois State Breastfeeding Task Force, IDHS is spearheading the development of a "Breastfeeding Blueprint for Illinois". The Blueprint will mirror the HHS Blueprint for Action and include an action plan for breastfeeding based on categories such as: education, training, awareness and support. New collaborations are being developed to provide a comprehensive plan with key recommendations and approaches in which "all interested stakeholders come together to forge partnerships to promote breastfeeding"

Chicago. The CDPH Breastfeeding program will ensure there is at least one certified lactation counselor and a breastfeeding room at every WIC site. All CDPH programs will continue to educate clients and the public about the benefits of breastfeeding, and to promote support for all women who choose to breastfeed. Plans include holding a Friend/Family Day at five WIC sites, with the focus on breastfeeding education including a question and answer period. Another plan is to have all staff answering WIC phones state "Breastfeeding is baby's first nutrition." WIC staff will continue to be active on the Chicago Breastfeeding Task Force. CDPH plans to continue supporting and coordinating the annual Breastfeeding Awareness Walk and Celebration. Finally, the CDPH will collaborate with Dr Paula Meier from Rush Presbyterian Hospital Neonatal Intensive Care Unit to produce a video to be used in clinics to promote breast-feeding practices among low income women, and in particular those who have premature and low birth weight infants.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	96	97	99	99.2
Annual Indicator	95.3	96.2	98.6	96.9	99.1
Numerator	173596	169068	170271	174909	170629
Denominator	182158	175659	172602	180530	172237
Data Source					IDPH, Vision & Hearing
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	99.2	99.2	99.2	99.2	99.2

Notes - 2008

Source: IDPH Vision and Hearing Screening Program, April 2009.

Notes - 2007

Source: IDPH Vision and Hearing Screening Program, 2008.

Notes - 2006

The number of children reported to IDPH Newborn Hearing Program is the number reported by birthing hospitals as opposed to registered births.

a. Last Year's Accomplishments

Provisional data from 2007 indicates 180,530 live births according to vital records. The Illinois Department of Public Health (IDPH) indicated 174,909 infants were screened prior to discharge and reported. These statistics suggest a 96.9% screening rate for year five of the program.

Preliminary 2008 data from IDPH indicates 172,237 infants to be screened. Of these infants 170,629 (99.1%) were screened prior to discharge. While data continues to arrive and follow-up is ongoing for the 6,890 (4%) of infants referred, and the 927 infants not screened, 193 infants born in 2008 have been identified with permanent hearing loss. The average age in months of identification of bilateral hearing loss was 3.6 months.

The Division of Specialized Care for Children (DSCC) was the recipient of the HRSA Universal Newborn Hearing Screening and Intervention grant. The funding supported the Illinois Newborn Hearing Program (INHP) coordinator at DSCC who oversaw day-to-day program operations, including public awareness activities, working with parents, and training of audiologists, physicians, local health departments and other stakeholders.

DSCC disseminated Newborn Hearing Medical Home flow charts, fact sheets and newborn hearing screening and follow-up brochures for parents to birthing hospitals and stakeholders. Informational brochures are provided at no charge in English, Spanish and Polish.

During year three of the HRSA grant, the INHP coordinator worked with EI regarding children with hearing loss. Through collaborative efforts, changes within Early Intervention Administrative Rules were proposed and accepted. Changes included: redefining criteria for automatic eligibility due to a hearing loss that would include mild and unilateral hearing loss, and allowing

audiologists with an Illinois license to participate in EI without additional credentialing requirements.

The INHP coordinator participated in the Joint Task Force on Deaf and Hard of Hearing Education Options. The charge of the task force was to "undertake a comprehensive and thorough review of education and services available to the deaf or hard of hearing children in Illinois with the intent of making recommendations." In the first year of the task force EI issues were addressed and systematic, legislative and resource recommendations were made with several already initiated.

In addition, DSCC supported the following activities: maintenance of the parent friendly, ADA compliant website, www.illinoisoundbeginnings.org; provision of information requested by the Illinois Academy of Audiology to support legislation for funding newborn hearing screening and follow-up activities; and work with parent groups to determine resources, mission and gaps in parent to parent support. Legislation was passed in the House and Senate in Spring 2008 and line item vetoed by the governor.

DSCC was awarded the next three year grant through HRSA that began April 1, 2008 to address Illinois' challenges related to infants lost to follow up. Activities such as technical assistance, data monitoring, and inter-agency collaboration were proposed and the use of the Plan Do Study Act Quality Improvement (NICHQ model) activities would be the primary focus of the grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospital screens each newborn for hearing loss.			X	
2. Test results reported to IDPH.				X
3. Parents and physicians are notified of abnormal test results and informed of diagnostic testing procedures.			X	
4. Diagnostic testing is performed by audiologists.	X			
5. Confirmed diagnoses are reported to IDPH.				X
6. Children with diagnosed hearing loss are referred to the Early Intervention and CSHCN programs.		X		
7. DSCC pays for diagnostic evaluation for families who cannot afford it or have insurance that does not cover it.	X			
8. IDHS convenes the Hearing Screening Advisory Committee and monitors program operation.				X
9.				
10.				

b. Current Activities

Grant funded quality improvement activities used the NICHQ learning collaborative model and focused on strengthening links between newborn hearing screening, definitive diagnosis, reporting to IDPH, referral to EI and connection to a Medical Home for identified infants. The project began with 4 northern metropolitan birthing hospitals. Nursery staff, administrators, audiologists, social workers, early interventionists and parents comprised the 30 to 40 participants in 3 onsite learning sessions, conference calls and email exchanges. Message scripting, 2nd point of contact and linking to a medical home were key concepts. Members were trained on the Early Intervention system, CSHCN program, IDPH data tracking, relating to deaf culture and communication access. Grant funds supported the coordinator to oversee daily operations and parent resources for birthing hospitals and other stakeholders.

DSCC supports IDPH in providing technical assistance to hospitals. The INHP facilitates linkages to the Part C and CSHCN Programs no later than 6 months of age, including linkages to family to

family support and medical home services. State partners collaborate on system issues. Efforts encourage new audiology providers to participate in the state Medicaid and Early Intervention Programs. Telephone and site visit support of hospital screening programs and diagnostic audiology clinics continue. The program summary was shared with the advisory committee and workgroups were established.

c. Plan for the Coming Year

DSCC will be in year two of a three year HRSA grant which ends March 31, 2011. Illinois will continue to address challenges related to infants lost to follow up from screening to diagnosis through intervention. Activities will support the use of the Plan Do Study Act Quality Improvement activities (NICHQ model).

Illinois was invited to participate in the complementary national NICHQ learning collaborative. Six to eight team members will travel to three on-site trainings, participate in webinars, teleconferences and other internet based learning. As part of the national opportunity, Illinois will implement the knowledge gained at the state level learning collaboratives.

Both the national and state learning collaboratives will focus on strengthening the links between newborn hearing screening, definitive diagnosis, reporting to IDPH, referral to EI and connection to a Medical Home for identified infants. The state level project will engage 3 to 5 birthing hospitals in central Illinois where birthing hospitals and follow-up services are not within the same system.

DSCC will continue to use UNHS grant funds to support the coordinator to oversee daily program operations, including public and professional awareness activities, training of audiologists, physicians, speech language pathologists, local health departments and other participants in the follow-up system. Parent resources will continue to be provided at no charge to the hospitals, physicians, Early Intervention agencies and health departments. DSCC will continue to support IDPH in providing technical assistance to the hospitals regarding newborn hearing screening and referrals.

IDHS, IDPH and DSCC will continue to collaborate on system issues in the state. Specific efforts will focus on identifying providers and encouraging new audiology providers to participate in the state Medicaid and Early Intervention Programs. Telephone and site visit support of hospital screening programs and diagnostic audiology clinics will continue. The advisory committee will be engaged in improvement activities as well as receive data and grant reports at the semi-annual meetings.

DSCC is applying for available supplemental grant funding to implement additional strategies for reducing loss to follow up.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6.8	6.7	6.6	5.9	5.9
Annual Indicator	6.7	6.0	5.9	4.1	4.1
Numerator	230000	204000	198000	138000	
Denominator	3409000	3424000	3339000	3366000	

Data Source					Census Bureau, Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	4.1	4	4	3.9	3.9

Notes - 2008

The final 2008 income data will be available when the Current Population Survey 2009 Annual Social and Economic Supplement will be released.

Notes - 2007

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement. Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2007.

Notes - 2006

The annual Social and Economic Supplement, Table H10 (Number and Percent of Children Under 19 at or below 200% of Poverty by Health Insurance Coverage and State: 2006 (SCHIP allocation formula).

a. Last Year's Accomplishments

IDHFS has partnered with over 1,300 community organizations, medical providers, and insurance agents who met as All Kids Application Agents to help enroll families throughout the state in All Kids and FamilyCare. All Kids, an affordable, comprehensive health insurance plan for all uninsured Illinois children age 18 or younger, was signed into law on November 15, 2005. When the plan went into effect on July 1, 2006 it pays for doctor visits, hospitalizations, dental care, vision care, prescription medications, medical equipment, and mental health services. The monthly premiums and co-pays are based on the family's income.

IDHFS mails information about All Kids to FCM and WIC recipients each year. Additionally, IDHFS mails a Member Handbook to all new members and makes it available on its web site: <http://www.allkids.com/customers/handbook.html>. Notices are mailed to families with children annually, and when they are due for a screen, based on the periodicity schedule. Client information is made available by the IDHFS and IDHFS' Illinois Health Connect (PCCM program) on web sites (<http://www.hfs.illinois.gov> and Illinois Health Connect (<http://www.illinoishealthconnect.com/>) and through direct, targeted notices.

Chicago. The Office of Health Care Access (OHCA) provides information and advocacy to consumers on Medicaid and Medicare eligibility, public health entitlement programs, and on private insurance options. In CY2007, OHCA developed and distributed nearly 459,000 maternal and child health-related printed publications to consumers and partners. All publications are printed in English and Spanish; publications in other languages are printed as needed. OHCA provides application assistance to state and federal programs for families through the CAREline call center and in neighborhood health and mental health centers. The OHCAA CAREline answered over 1,400 calls from community residents having difficulty with their public health care

plans. OHCA is the CDPH liaison for Illinois Health Connect, the state's primary care case management program, and for Your Healthcare Plus, the state's disease management program. In CY'08, the CDPH completed more than 3,300 All Kids applications. All Kids administration now resides in OHCA.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDHS grantees assist families in applying for All Kids and FamilyCare		X		
2. DSCC requires eligible families to apply for All Kids		X		
3. IDHFS covers uninsured children through All Kids		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Of children enrolled in WIC, 94.1 percent had All Kids or other insurance coverage. FCM providers are required to document giving parent information regarding Illinois' All Kids program and information on how to enroll. This information is recorded in Cornerstone and quarterly performance reports are issued to track compliance. Most FCM providers are All Kids agents, which allows them to assist clients in completing applications on-site. Healthy Start and Targeted Intensive Prenatal Service providers also are required to disseminate information concerning All Kids coverage to new clients at time of program enrollment.

Chicago. Through its OHCA, clinics, home visiting programs, collaboration with other organizations and health fairs, CDPH staff continues to increase its emphasis on educating families and enrolling eligible individuals in All Kids and FamilyCare, and pregnant women in Moms & Babies and Medicaid Presumptive Eligibility (MPE.)

c. Plan for the Coming Year

IDHS and IDHFS will continue to promote enrollment in All Kids to reduce the proportion of children without health insurance. IDHS will use the Cornerstone system to monitor the number of WIC/FCM eligible children who do not have insurance coverage. These children will be targeted by local WIC and Family Case Management grantees for additional outreach efforts to encourage their parents to enroll them in All Kids. IDHFS will continue to provide training and field staff support to All Kids Application Agents (AKAAs). SHCs will determine insurance status of all enrolled students and refer those without insurance to All Kids. Families can apply for All Kids or FamilyCare online at www.allkids.com, by mail through an AKA or at an IDHS Family and Community Resource Center.

In addition, the Healthy Child Care Illinois Program Child Care Nurse Consultants provide All Kids enrollment information to all of Illinois' child care providers and families who attend outreach education programs.

IDPH requires Dental Sealant programs to educate and enroll families in All Kids.

Chicago. CDPH staff will continue to increase its emphasis on enrolling eligible individuals in various state-sponsored health insurance programs including Medicaid, All Kids, FamilyCare, Moms & Babies, and Medicaid Presumptive Eligibility. Enrollments will be done by FCM, PHN, Immunization Program, and the clinics, as well as staff from the OHCA. The OHCA will continue to provide education for both providers and the community, and will continue to operate the CAREline. The OHCA's monthly call-in television show, CAREline Up Close brings information on state and federal health care programs to one million Chicago households each month.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			24	23	29.9
Annual Indicator		24.2	29.8	29.9	30.0
Numerator		19718		109549	63414
Denominator		81616		366250	211100
Data Source					PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	29.8	29.5	29	28.5	28.5

Notes - 2008

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2008, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2008 numerator: PedNSS state data; denominator: estimated to make published rate.

Notes - 2007

Source: Table 2C-Summary of Health Indicators, Children Aged <5 Years, Illinois 2007, CDC's Pediatric Nutrition Surveillance System (PedNSS). 2007 numerator: PedNSS state data; denominator: estimated to make published rate.

Notes - 2006

Source: In March, 2007, the Illinois Cornerstone system was the source for 25.4 percent or 20,280 of state WIC children with high BMI. Cornerstone had been the source for 2005 and 2006. The 2006 data previously reported as 'final' will be revised this year.

The CDC's Pediatric Nutrition Surveillance System (PedNSS) will be the source for this measure hereafter and will be reported on Form 11 as a percentage only. The revised percentage for 2006 is 29.8.

a. Last Year's Accomplishments

In 2008, 30.0 percent of children between 2 and 5 years of age who received WIC services had a BMI score at or above the 85th percentile. Illinois is following the national trend in the epidemic of overweight/obesity. The prevalence of overweight in children (2-5 years of age) in Illinois has

gradually increased from 9.3 percent in 1976 to 15.3 percent in 2008. An additional 14.7 percent of children in the same age group are considered "at-risk" for being overweight. The national average for overweight is 16.4 percent and at-risk is 14.9 percent (Pediatric Nutrition Surveillance System 2008).

The Division of Community Health and Prevention (CH&P) is in a unique position to impact childhood obesity. Within CH&P, the WIC Program is able to educate mothers during their pregnancy about weight gain, healthful eating and breastfeeding. Breastfeeding and early eating habits are important and nearly 50 percent of infants born in Illinois participate in the WIC Program, thus receiving prevention messages from the start. Routine contacts with WIC continue throughout the 4th year of life. In 2007, WIC served over 354,000 infants and children allowing multiple assessment and education contacts with families. CH&P provides after-school programming to children age 7-18 as well. Staff from the Bureau of Family Nutrition provides in-services to providers on participation in the Child and Adult Community Food Programs to ensure quality, healthy, foods are offered and reimbursed by the Illinois State Board of Education.

Nationally in WIC there is a movement to improve rapport with participants in order to assist them in making behavior changes needed to achieve overall health, including healthy weights. Training events in 2008 focused on making these connections.

"Transforming Nutrition Education: What's Love Got to Do with It?" A statewide workshop was held in May. Over 200 local agency staff attended to learn more about how emotions drive behavior, why materials/approaches should be based on emotion vs. logic, how to be more persuasive with participants, how and why the hopes and dreams of mothers need to be connected to desired WIC behaviors. Pam McCarthey presented the keynote presentation and skill building sessions were held throughout the remaining 1 1/2 days. As follow-up to the statewide event workshops were held across the state throughout the fall and winter to ensure local WIC staff possess the skills needed to provide effective nutrition education and counseling.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train IDHS BFN Nutrition Staff on obesity prevention and intervention strategies.				X
2. Train local WIC Providers on obesity prevention and intervention strategies.	X			
3. Collaborate with community partners such as CLOCC and the Illinois Interagency Nutrition Council to create common messages and maximize resources.		X		X
4. Provide nutritious foods through the WIC, CSFP and WIC Farmer's Market Nutrition Programs.	X	X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WIC Program in partnership with the University of Illinois Extension continued to provide "Cooking School" Programs in 2008. The project will continue in 2009. Sessions are bi-lingual and held for four days. Students learn the basics of cooking using WIC foods. Discussions are being held on how to expand the project beyond Chicago.

IDHS staff remains involved with the Consortium to Lower Obesity in Chicago Children (CLOCC). Bureau of Family Nutrition staff participates in the following workgroups: Early Childhood, Health Communities, and Government Policy. The Bureau is listed in the CLOCC Program database which can be found on the website www.clocc.net.

The Illinois State Nutrition Action Plan (I-SNAP) involves all USDA Food and Nutrition Section programs in Illinois and is carried out through the Illinois Interagency Nutrition Council (INC). Goals of I-SNAP are to: promote adoption of healthy dietary patterns and regular physical activity based on key messages in the Dietary Guidelines for Americans; and promote Healthy Community and School Nutrition Environments by increasing awareness about the importance of a healthy school nutrition environment. The group is sharing common messages released by USDA in the fall related to parenting, food, and feeding relationships.

In 2008 the Illinois WIC Farmers Market Nutrition Program was expanded to 10 counties. These counties will be maintained in 2009.

c. Plan for the Coming Year

The Southern Illinois Healthy Child Task Force has been funded for SFY2010 to continue their efforts to prevent and address childhood obesity in southern Illinois. The group continues to meet regularly with good attendance and sharing of information and grant opportunities.

In August 2009, the new WIC Food Packages will be implemented in Illinois. These packages will provide more culturally appropriate foods and are designed to align with the Dietary Guidelines for Americans. Participants will receive fresh, frozen or canned fruits and vegetables, a choice of whole grains including 100 percent whole wheat bread, brown rice, soft corn tortillas and oatmeal and reduced fat milk (except those under 2 years of age). Participants will receive less cheese, eggs, whole milk, and juice. In addition a strong focus on exclusivity of breastfeeding is included with these changes. Illinois is part of several research projects evaluating the impact of the new food packages on participant overweight and the availability of nutritious foods at a community level.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			12.4	12.2	10
Annual Indicator		12.6	12.1	10.4	11.4
Numerator		23000		17586	19380
Denominator		182393		169356	169854
Data Source					IDPH, PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013

Annual Performance Objective	11	11	10	10	10
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Notes - 2008

Source: 2006 PRAMS, Illinois Department of Public Health (IDPH). 2007 PRAMS data were not available for this application from IDPH.

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

Notes - 2007

Source: 2005 PRAMS, Illinois Department of Public Health (IDPH).

The objectives for 2008-2012 have been adjusted to account for the decline of women who smoke in the last trimester as reported in the 2004 and 2005 PRAMS.

Notes - 2006

Source: 2004 PRAMS, Illinois Department of Public Health (IDPH). In 2004, among moms who reported receiving WIC services while pregnant, 17.8% reported smoking in the last trimester. Among moms not reporting WIC services, 8.0% reported smoking in the last trimester. 2005 and 2006 PRAMS data were not available for this application from IDPH.

a. Last Year's Accomplishments

As of 2008, 11.4 percent of women reported smoking in the last trimester of their pregnancy. Non-hispanic women, as well as black and white women were more likely to smoke during all three time periods when compared to Hispanic women and women of all other races. Women with less than a high school education reported smoking more often during all time periods when compared to women with more than a high school education. Unmarried women and women whose deliveries were paid for by Medicaid reported much higher rates of smoking during all three time periods when compared to married women and women whose deliveries were not paid for by Medicaid.

In February 2005, the IDHS, IDPH, and IDHFS announced a new initiative to reduce smoking among women who are participating in WIC, FCM, and other MCH programs. This initiative builds on and extends the work that local health departments and other agencies have been doing to promote smoking cessation among women who are pregnant or who have infants or young children. It has three components: implementation of the "Five A's;" use of the Illinois Tobacco QuitLine; and reimbursement of smoking cessation medications through the Medicaid Program.

MCH program staff were encouraged to enhance their current procedures by implementing the recommendations of the American College of Obstetricians and Gynecologists (ACOG). Their recommendations include the following steps, often referred to as "the five A's":

- Ask about tobacco use;
- Advise women to quit;
- Assess willingness to make a quit attempt;
- Assist in the quit attempt; and
- Arrange follow-up.

Pregnant or parenting women who are smoking may be referred to the American Lung Association QuitLine for ongoing assistance. The Illinois Tobacco QuitLine was developed by IDPH and the American Lung Association, and is supported by Tobacco Settlement Funds. The QuitLine offers free, confidential counseling to smokers related to all stages of the quitting process, including nutrition and weight management, information about cessation medications, and management skills for dealing with withdrawal symptoms. QuitLine Staff will make appointments with callers for follow-up and provide on-going support through the process of quitting.

All callers, regardless of income, are eligible to receive counseling services. QuitLine hours are 7:00 AM to 7:00 PM (CST), Monday through Friday. Bilingual services are available. The QuitLine is staffed by registered nurses and respiratory therapists who have been trained at the Mayo Clinic. Enrolled pharmacies may bill the IDHFS Medicaid program on behalf of eligible women for certain medications and over-the-counter items to assist them in quitting the use of tobacco. IDHFS covers both prescription and over-the-counter smoking cessation products when obtained with a prescription.

Chicago. CDPH's Women's Maternal Smoking Intervention program operates in WIC sites and CDPH Clinics. In 2008, the program provided services to 340 women, 10 percent less more than in 2007. There were 172 women who were pregnant, of which 113 (66 percent) quit smoking, and 47 (24 percent) who cut down on their smoking. Also, 84 percent of all program women stopped smoking in front of their children. The Women's/Maternal Smoking Intervention program continued incorporating the NicAlert nicotine exposure screening to demonstrate exposure to secondhand smoke with WIC clients, motivating more women to report their smoking and smoking of others in their homes. The program also collaborated with the Breast and Cervical Cancer Screening Program using the nicotine exposure screenings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of the "Five A's" in MCH programs		X		
2. Promote the Illinois Tobacco QuitLine			X	
3. The Medicaid program reimburses the cost of smoking cessation medications				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A new on-line training module will be available to WIC and other IDHS health professionals via the Community Health Training Center. The module focuses on high-risk WIC participants. A portion of the module addresses the risks of smoking during pregnancy and the "Five A's" of smoking cessation.

Each Illinois WIC participant is required to receive education on the dangers of drugs, alcohol and tobacco. Key messages are displayed at local WIC offices via posters and brochures and are discussed during regular visits. Key messages are highlighted on the back of the Illinois WIC Food List which is given to every participant.

Chicago. The Women's/Maternal Smoking Intervention Program encourages providers to ask all women about their tobacco use. The provider will advise the smoker to quit and will offer materials that are supplied by the Illinois Tobacco-Free Communities (ITFC) grant, including a self-instruction booklet entitled "It's Time" (to quit), when it is assessed that the smokers want to quit. If the smoker wants additional assistance by phone, the ITFC representative will call them with further counseling and follow-up in three and six months. The ITFC representative will recommend the Illinois Tobacco QuitLine and the FREE "Courage to Quit" smoking cessation program where FREE nicotine replacement therapy is provided by ITFC.

c. Plan for the Coming Year

The IDHS, IDPH, and IDHFS will continue the initiative to reduce smoking among women who are participating in WIC, FCM, and other Maternal and Child Health programs. Pregnant or parenting women who are smoking will be referred to the American Lung Association QuitLine for ongoing assistance. Agencies will use a smoking cessation curriculum, i.e. Make Yours A Fresh Start Family, to help clients quit or decrease their smoking. Materials will be available, at no charge, for use in promoting the QuitLine and the importance of smoking cessation to women who are participating in the WIC and FCM programs. Information on the smoking status of participants will be monitored through the Cornerstone System, and client progress available to providers on a quarterly basis. Additionally, IDHFS will be implementing several smoking cessation training initiatives in the next year to pilot evidence-based practices and evaluate results.

In 2008, a new WIC Risk Factor was added related to environmental tobacco smoke exposure. Early data indicates about 17 percent of pregnant women report a member of the household smoking inside the home. Assessing for this risk creates a new opportunity for awareness and education on the risks of second-hand smoke to women, infants and children.

Chicago.

The Women's/Maternal Smoking Intervention program will continue its NicAlert nicotine exposure screening in WIC clinics, and expand this screening in collaboration with the Infant Mortality Reduction Initiative. In addition, Smoke Free Homes and Cars will be promoted in clinics in collaboration with the EPA.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	5.4	5.4	4.7	6	6
Annual Indicator	6.7	5.5	5.1	5.1	5.1
Numerator	61	50	48		
Denominator	905322	916148	939462		
Data Source					IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	5	5	5	5	5

Notes - 2008

Vital Records data for deaths in 2007 or 2008 are not available at this time. Refer to the general Form 11 Note.

Notes - 2007

Vital Records data for deaths in 2007 or 2008 are not available at this time. Refer to the general Form 11 Note.

Notes - 2006

Source: IDPH Vital Records - death data for 2006.

a. Last Year's Accomplishments

All 40 School Health Centers provide mental health counseling on-site and/or have agreements with outside community providers for individual, group, or inpatient care as needed.

The mental health committee within the Coalition for School Health Centers developed and distributed to the centers a document entitled "Suicide Assessment and Management: Guidelines for Illinois [School Health Centers]." Training was provided via satellite to DCHP staff and contractors on signs, causes, and referral procedures on adolescent suicide.

Below are highlights of the Illinois Department of Public Health's suicide prevention activities.

- The Illinois Suicide Prevention Strategic Plan was officially released through the Illinois Department of Public Health.
- \$350,000 was allocated by the Illinois State Legislature in the FY08 budget to suicide prevention. The Department of Public Health contracted with the Mental Health America of Illinois (MHA) to implement activities during FY09 due to the late release of the FY08 funding to the Department of Public Health. The contract included development a public awareness campaign, building local coalitions, provide data analysis, train providers in the field of aging, education and human services, in addition to including an evaluation component.
- Submitted an application for youth suicide prevention activities to the Substance Abuse and Mental Health Services Administration.
- Submitted an application to the Substance Abuse and Mental Health Services Administration to implement youth suicide prevention activities.
- Provided a grant, through general revenue funds, to the Children's Memorial Hospital, Children's Data Lab to continue to implement the Illinois Violent Death Reporting System in three counties. (More than half of the violent deaths in the system are suicides.)
- Provided funds, through general revenue funds, to the Farm Resource Center to offer outreach crisis intervention.
- Collaborated with the Pacific Institute for Research and Evaluation to update the Illinois data fact sheet sponsored by the Suicide Prevention Resource Center.
- Provided technical assistance to state and local entities as well as conducted presentations and displays.

The Illinois Suicide Prevention Alliance serves as the advisory board to the Illinois Department of Public Health. Below are highlights of some of the accomplishments from the IDPH Director Appointed Illinois Suicide Prevention Alliance: 1) Illinois Suicide Prevention Strategic Planning Committee was renamed the Illinois Suicide Prevention Alliance, - Public Act 095-0109 - effective January 1, 2008; 2)The IDPH Director Appointed Illinois Suicide Prevention Alliance met bi-monthly; 3) A report entitled State Agency Review and Initial Recommendations Report: Recommendations of Policy and Program Changes to Support Suicide Prevention was submitted for Department of Public Health approval. The report included recommendations to the Illinois Department of Public Health, Illinois Department of Human Services, Illinois State Board of Education and the Illinois Department on Aging; and 4) Provided technical assistance to community-based teams to create local suicide prevention efforts.

Chicago. The Chicago Public Schools receive funding from CDC to monitor critical health

behaviors in youth through implementation of the Youth Risk Behavior Survey (YRBS.) Data are collected on a biannual basis. In 2007, 13.4 percent of students had seriously considered attempting suicide during the 12 month period before the survey, and 10.1 percent had made a plan. This was higher than the 2005 percentage of 12.9. percent who had considered suicide and approximately equal to the 10.6 percent who had made a plan.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The School Health Centers provide mental health counseling	X			
2. Mental health counseling services are available on-site from two Teen Parent Services program offices	X			
3. IDHS provides training on the risk factors for adolescent suicide				X
4. IDHS distributes information on teen suicide through the school health program				X
5. IDHS participates in the Illinois Suicide Prevention Alliance				X
6. IDPH will ensure that prevention programs serve as school gatekeepers and provide faculty training				X
7. IDPH will ensure that prevention programs conduct community gatekeeper training				X
8. IDPH will ensure that prevention programs provide community-based general suicide prevention education			X	
9. IDPH will ensure that prevention programs include health providers and provide physician training and consultation about high-risk cases				X
10. IDPH will ensure that prevention strategies include depression, anxiety, and suicide screening programs			X	

b. Current Activities

Through state funds, the Department of Public Health contracted with the Mental Health America of Illinois to implement suicide prevention activities across Illinois. These activities included:

- Coordinated and implemented the Suicide Prevention Resource Center's (SPRC) two-day Core Competency Training for communities interested in developing local suicide prevention coalition projects to assist in implementing the state plan.
- Planned for the launch of a public awareness campaign, entitled "It Only Takes One" in Chicago along with a series of smaller launches throughout the state.
- Awarded seven mini-grants to appropriately qualified and trained organizations in Illinois to provide professional development on suicide prevention to schools and school districts in Illinois.
- Provided training to professionals in the aging network during their respective conference.
- Worked with the University of Illinois Center for Prevention Research and Development to evaluate the suicide prevention activities.

Chicago: CDPH does not specifically address adolescent suicide; however, most CDPH programs have policies and procedures related to crisis intervention, and provide clients with educational materials on depression and other conditions that can lead to suicide.

c. Plan for the Coming Year

IDHS will continue to work with the Illinois Coalition of School Health Centers to provide mental health counseling services. A standard encounter form has been developed to document mental health services provided at each site. Preventive health education activities will be conducted. Coordinated School Health Projects utilize the eight components of a Coordinated School Health

Program Model to provide prevention activities. These programs and activities focus on teen issues, including self-esteem, violence prevention, student assistance programs, alcohol/substance abuse prevention, sexual abuse, and date rape prevention.

Through use of discretionary funds, IDPH will monitor the prevention strategies as outlined in the Suicide Prevention, Education, and Treatment Act. It is hoped that IDPH receives funding from SAMSHA to carry out these objectives.

Illinois has 12 certified local crisis centers that are part of the National Hopeline Network, and eight mutual local crisis centers that are part of the National Prevention Lifeline Network. There are more small local crisis centers currently not part of any network.

Through state funds, the Department of Public Health will again contract with the Mental Health America of Illinois to implement additional suicide prevention activities across Illinois. It is anticipated these activities will center on expanding the public awareness campaign, training professionals, supporting local initiatives and enhancing data. The activities will reflect the recommended next steps outlined in the Illinois Suicide Prevention Strategic Plan. The Department of Public Health will continue to facilitate the Illinois Suicide Prevention Alliance and their activities which will include meeting on a regular basis, creating an annual report and serving as an advisor to the Department of Public Health.

Chicago. CDPH programs will continue to address crisis situations according to existing policies and procedures and provide clients with educational materials on depression and other conditions that can lead to suicide. Chicago Public Schools will continue to conduct the YRBS and monitor adolescent high risk behavior.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	82	83.5	83.5	81	82
Annual Indicator	81.1	81.0	83.1	82.6	82.6
Numerator	2451	2375	2464	2427	
Denominator	3024	2932	2964	2938	
Data Source					IDPH, Perinatal
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	83	83	83	83	83

Notes - 2008

Source: IDPH, Center for Health Statistics. The 2007 Annual Indicator must be reported again in 2008.

Notes - 2007

Source: IDPH, Center for Health Statistics.

Notes - 2006

Source: IDPH, Center for Health Statistics, MCH Block Grant Natality Data, 2006 (received 8/2008).

a. Last Year's Accomplishments

In 2007, there was a slight decrease in the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. However, at 82.6 percent, Illinois' performance on this measure registers as improved compared to earlier years.

Primary responsibility for directing the Illinois Perinatal Program was shifted back to the Illinois Department of Public Health. IDPH is working with the IDHS on the implementation and coordination of other MCH/perinatal programs and activities, such as the Fetal and Infant Mortality Review (FIMR) Project, Early Intervention (EI) Program, the Chicago Healthy Start Initiative, and the Closing the Gap project.

IDPH and the Statewide Quality Council have worked very closely with each of the ten perinatal networks on the monitoring and evaluation of the percentage of the very low birth weight infants born in a Level II+ or Level III facility. The methodology for incorporating perinatal outcome surveillance and plans for improving provider compliance with consultation, referral, and transfer protocols for high-risk maternal and neonatal patients are in place at all facilities, as well as the monitoring system for outcomes for the purpose of quality assessment and improvement.

Chicago. In 2006, 712 very low birth weight infants were born to Chicago residents. Of these, 592(83.1%) were born at Level III and Level II+ hospitals, locations capable of providing care for these infants. The 2005 percentage was 80.0. CDPH does not have data to determine the percentage of infants who were born at inappropriate facilities but were transferred to more appropriate facilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Each perinatal center uses continuous quality improvement to increase the proportion of infants born in Level II+ or Level III Centers			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Each of the 10 perinatal networks, as well as IDPH and the Statewide Quality Council, are monitoring and evaluating the percentage of very low birth weight infants born at appropriate facilities, and in-depth educational opportunities are given to those facilities who may have problems assessing those patients who should be transferred to a higher level of care.

The Director of IDPH, based on a recommendation from the Perinatal Advisory Committee (PAC), sent a letter introducing the Maternal Hemorrhage Education Project to the Perinatal Network administrators and to the Chief Executive Officers of all hospitals providing maternity services in Illinois. The project is in response to the Maternal Mortality Review Committee's (MMRC) past and continuing findings that the majority of mortality cases occurred while women were hospitalized, that these mortalities occurred at every level of care throughout the state, and that women from all socioeconomic groups were affected. The goal of the project is to improve and reduce maternal morbidity and mortality due to obstetric hemorrhage. Each hospital received one million dollars to fund the program and will be required to submit an education and simulation drill schedule prior to implementing the project. The development of a hospital specific obstetric hemorrhage assessment and rapid response policy will be included as part of re-designation requirements and hospitals will have until December, 2009 to adopt a policy.

c. Plan for the Coming Year

This performance measure will be addressed by IDPH through the routine operation of the perinatal care program.

Chicago. The CDPH and members of the CMCHAC will continue to participate in Perinatal Advisory Committee meetings as necessary and assist in the development of perinatal rules and regulations. However, IDPH rather than CDPH will monitor the care provided by the Perinatal Centers and services provided by the Level II and Level II+ hospitals.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	84	84	82	82	87
Annual Indicator	80.7	81.8	86.1	86.0	86
Numerator	145862	146265	148860	145898	
Denominator	180665	178872	172853	169616	
Data Source					IDPH, Center for Health Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	86	87	87	87	87

Notes - 2008

Only the provisional total number of births for 2008 have been released by IDPH.

Notes - 2007

Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2006 (received 8/2008). These data have been revised and received along with the 2007 final data. An additional 10,914 infants were born to mothers with unknown trimester of prenatal care and excluded from the total number of births.

Notes - 2006

Source: IDPH, Center for Health Statistics, MCH Block Grant, Natality Data, 2006 (received 8/2008). These data have been revised in May 2009. An additional 7,650 infants were born to mothers with unknown trimester of prenatal care and were excluded from the total number of births.

a. Last Year's Accomplishments

Illinois did not meet its newly established target of 87 percent of women who began prenatal care in the first trimester of pregnancy. The most recent data available, 2007, reports that Illinois fell short by one percentage point; 86 percent of women began prenatal care in the first trimester.

The Teen Parent Services program has addressed this goal through its integration and collaboration with the FCM program. Upon identification, eligible pregnant teens are immediately referred for FCM services in those agencies that do not provide both programs.

The goal of IDHFS's Medicaid Presumptive Eligibility (MPE) program is to promote early and continuous prenatal care to low income pregnant women. Through presumptive eligibility, women are covered for prenatal care services from the date of the MPE determination. (That determinations made by MPE providers who assist the woman in the application process for ongoing assistance under Title XIX with the All Kids application completed at the same time.) Approximately 3,800 women are enrolled in MPE each month.

The IDHS, IDHFS, and the Steans Family Foundation implemented the Healthy Births for Healthy Communities initiative on July 1, 2006. The initiative is using a performance-based reimbursement strategy to pay for outreach activities in two Chicago Community Areas (Austin and North Lawndale). Two community-based organizations are conducting grassroots outreach efforts to engage multiparous women who are at increased risk of delivering a very low birth weight infant in WIC, FCM, Healthy Start or TIPCM. The IDHFS is matching the funds provided by the foundation and transferring these funds to IDHS. The Title V program, in turn, is managing the grants to the community-based organizations. Additional funds will be provided during the year to area hospitals to ensure that women are linked to the program by their emergency departments. The project partners are collaborating to develop an interconceptional care (case management) component for implementation later in the year. The project has been developed with the active participation of Closing the Gap and Westside Healthy Start.

Since its inception, Healthy Births for Healthy Communities initiative reported 380 women participants. The women enrolled are a high-risk group: 67 percent report having medically high-risk conditions such as chronic disease, previous pre-term birth, and less than 12-month interpregnancy intervals. The others have social risk factors such as homelessness and domestic violence. The project is measuring the effort it takes to find these high-risk women. On average, it is taking nearly five hours to find and enroll one high-risk woman.

The Targeted Intensive Prenatal Program (TIPCM) received \$7.6 million in funding in FY08, and 4,451 women were enrolled. The TIPCM target population consists of "hard to reach high-risk pregnant women" who reside in fourteen target areas throughout Illinois. The most common risk factor for inclusion in the program is presence of a chronic disease that impacts pregnancy (25.2%), followed by greater than 4th pregnancy or third child expected (12.8%), and previous preterm birth (12.6%). Other risks found include DSM IV Classification (8%), Homeless/temporary Housing (7.7%), victim of domestic violence (7.1%), and low educational attainment (6.8%).

These have been the 7 most common risk factors the past four years. Performance data indicates 66.7% of the women in TIPCM residing in Cook County received adequate prenatal care, as did 67.6% of women downstate in TIPCM programs. In FY07 58.6% of women in TIPCM in Cook County received adequate prenatal care, while 64.8% did downstate.

In FY08, 199 clients received Doula services in four IDHS funded service sites: Alivio Medical Center, Christopher House, Marillac Social Center, and Easter Seal Developmental Center in Rockford. The target population is pregnant teens. Illinois is believed to have the most extensively available publicly funded Doula services and the only statewide network providing Doula services to teenagers and young parents in the nation.. The Ounce of Prevention receives the grant funding from IDHS, and they then works directly with the four project sites. They also fund several other Doula projects in Illinois. Early entry into prenatal care is an expected outcome of program participation

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCM and other case management programs conduct outreach and case finding activities		X		
2. Local health departments and WIC programs help women complete Medicaid Presumptive Eligibility applications		X		
3. FCM and other case management programs help women obtain medical care		X		
4. Family Planning programs conduct options counseling and refer women to prenatal care providers	X			
5. IDHS and IDHFS partner with private foundations to improve outreach in targeted communities		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local IDHS office staff are being trained to routinely ask women of childbearing age if they are pregnant and, if so, to record this information in the Department's data system. This information is then shared with FCM and Chicago Healthy Start Initiative (CHSI) agencies, so staff can conduct outreach efforts and assist women with obtaining prenatal care.

The Illinois Perinatal Mental Health Disorders Prevention and Treatment Act became effective 1/1/08. The Act requires that prenatal, postnatal and pediatric care providers educate women and their families about perinatal depression and offer screening. The Act identifies IDHS as having responsibility to provide education and training materials to providers. As a result, the Department provides access to trainings, brochures, treatment and referral services through linkage with the University of Illinois at Chicago, Evanston Hospital and Healthcare Alternative Systems. A sub-committee of the MCH Advisory Board was convened in the summer of 2008 to develop the rules and regulations that will accompany the Act.

Chicago. CDPH continues to conduct outreach activities to identify and recruit high-risk pregnant women, promote postpartum and family planning visits to decrease unplanned pregnancies,

enroll women in care following a positive pregnancy test result, and encourage newly-pregnant women to continue in care.

c. Plan for the Coming Year

The Title V program will address this performance measure by continuing current strategies to increase the proportion of women who begin prenatal care in the first trimester, including referrals from Family Planning programs, outreach and case finding activities through Family Case Management, integration of WIC and FCM services, integration of TPS and FCM programs, and the operation of School Health Centers.

The Doula project will focus attention on two observed sequelae to its services, breastfeeding initiation and post partum depression prevention. Program data indicates a 57 percent rate of initiation for Doula participants; a rate above the national norm for US teenagers. The Ounce and site staff will rededicate efforts to strengthening this outcome. The second area of research is the impact of Doula services on rates of suspected postpartum depression. Smaller studies done with two Doula programs (part of the Ounce's wider Doula network), demonstrated significant decreases in suspected rates of depression in comparison to a control group at the same site.

Chicago. CDPH's strategies of providing outreach to identify and recruit high-risk pregnant women, promoting postpartum and family planning visits to decrease unplanned pregnancies; enrolling women in care following a positive pregnancy test result, and encouraging newly-pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care. CDPH has contracts with seven hospitals to provide midwifery-based prenatal and family planning services in five of its Neighborhood Health Centers.

D. State Performance Measures

State Performance Measure 1: *The incidence of maltreatment of children younger than age 18*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	7.8	7.7	7.9	7.8	7.8
Annual Indicator	7.8	7.9	7.6	8.1	8.6
Numerator	25423	25571	24772	26399	27947
Denominator	3240000	3220000	3240000	3240000	3240000
Data Source					IDCFS
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	8.8	8.7	8.6	8.5	8.5

Notes - 2008

Source: Tables 4 and 8, 2008 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

Notes - 2007

Source: Tables 4 and 8, 2007 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

Notes - 2006

Source: Tables 4 and 8, 2006 Annual Report, Illinois Department of Children and Family Services website. The denominator is an arbitrary number to arrive at the reported number and rate of children indicated as an unduplicated count within the State.

a. Last Year's Accomplishments

The rate of child maltreatment has increased to 8.6 per 1,000 children; the rate was 8.16 per 1,000 children in 2007. Since 2006, the rate of child maltreatment increased 13 percent. Many factors underlie maltreatment including financial insecurity. Perhaps the recent increase in child maltreatment is due in part to the worsening economic situation of many young families.

Healthy Families Illinois (HFI) seeks to prevent child abuse and neglect through intensive home visits that improve family functioning, enhance the parent child relationship, encourage positive parenting, and promote healthy growth and development. Findings from a longitudinal evaluation of HFI conducted by Northern Illinois University indicated that the program is effective in engaging and retaining at-risk families, and in reducing the risk for child maltreatment in families determined to be at the greatest risk for child maltreatment at enrollment. The Department currently supports 49 HFI programs throughout the state. The Parents Too Soon, Parents Care and Share and the High-Risk Infant Follow-up programs also address the prevention of child abuse and neglect.

Chicago. According to the DCFS reports, the incidence of reported maltreatment of children consistently has declined: 6,558 children in 2003, 6,067 children in 2004, 5,275 children in 2005, and 5,129 children in 2006. Public health nurses and outreach workers assess clients and help mothers develop parenting skills. Through its Community Development Block Grant, the CDPH monitors seven community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for follow-up as needed. These seven community agencies provided services to 919 clients in 2007. The Healthy Families program that CDPH operates in partnership with Metropolitan Family Services provides services in the South Chicago area. In 2007, Healthy Families provided services for 65 at-risk families. In 2007, the CDPH program, Greater West Side of Chicago Early Childhood Network (providing services in North/South Lawndale and East/West Garfield), sponsored two forums on child abuse and neglect, one for providers and the other for families. CDPH allows domestic violence agencies access to WIC and CDPH clinics to assess and provide counseling to clients.

The Chicago Safe Start (CSS) initially was funded in 2000 as a part of the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention's national demonstration project housed in CDPH's Office of Violence Prevention. The program's mission is to prevent and reduce the negative impact of exposure to violence on children ages six years and younger. This work is achieved through a balance of prevention and intervention efforts focusing on education, professional development, direct service innovation, and systems change oriented collaboration among city and state service providers, community organizations, and residents. The program has worked to influence many systems that have contact with infants and children exposed to violence. The Safe Start evaluation indicates that their clients are improving as a result of the clinical services rendered. Since 2003, CSS has provided over 500 citywide training events reaching approximately 10,000 participants. Training evaluations conducted at least 18 months after participating in CSS training, show that 87 percent of participants were more aware of the problem of childhood exposure to violence, and 79 percent reported doing more personally to address childhood exposure to violence. From 2002 to 2007, 1,629 children were referred to CSS contracted delegate agencies for exposure to violence services. In 2008, CSS celebrated the second annual Chicago Safe Start week, which was authorized via a mayoral proclamation. CSS held an art exhibit featuring acclaimed local artist Jodi Bova highlighting Childhood Exposure to

Violence, and a celebration brunch with 40 of CSS's organizational partners and independent professionals across disciplines.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Families Illinois provides voluntary home visits to at-risk families with young children		X		
2. Parents Too Soon programs provide home visits and peer groups to first time teen parents		X		
3. Other teen parenting programs help clients develop effective parenting skills		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

HFI works with families who are at risk of child maltreatment. A goal of the intervention is to help the primary care giver be aware of and attend to the "internal life" of the baby.

The Strengthening Families Initiative educates a network of childcare providers to utilize protective factors around families to build resiliency. This initiative will operate in Kane County, North Lawndale Community Area in Chicago, southern Cook County, Peoria, and the "Southern 7" Counties (Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union Counties).

Parents Care and Share is a network of parental support groups to prevent child abuse and neglect by helping parents to increase their protective factors. .

Another important initiative is the collaboration of IDHS, DCFS and to develop the state's infrastructure for the support of evidence-based home visiting programs. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment."

Chicago. Chicago Safe Start continues to partner with four service providers that provide family support and mental health services to children ages five years and younger who have been exposed to violence, along with their families.

c. Plan for the Coming Year

This performance measure will be addressed by the HFI, PTS and Parents Care and Share programs. The MCH program will also work closely with the IDCFS to implement the Strengthening Families Initiative.

Chicago. Through its Community Development Block Grant, the CDPH will continue to monitor community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for follow-up as needed. The CDPH staff also will continue to

assess women for domestic violence and refer them for counseling, and will continue to allow domestic violence agencies access to WIC and CDPH clinics to provide assessment and counseling to clients. Healthy Families will continue providing services in the South Chicago area. Greater West Side of Chicago Early Childhood Network will offer two forums (one for providers and one for parents) focusing on breaking the cycle of sexual abuse.

State Performance Measure 2: *The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	74	77	80.9	85	81.9
Annual Indicator	76.3	80.8	82.2	81.7	82.7
Numerator	1602	1651	1612	1574	1548
Denominator	2100	2043	1960	1926	1872
Data Source					Record Review DSCC Youth 14-21
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	82.8	82.8	82.9	82.9	83

a. Last Year's Accomplishments

Illinois' performance objective to ensure that 81.9% of youth over 14 years of age and their parents receive comprehensive transition planning from DSCC staff was achieved. Actual performance in FY '08 was 82.7%, which is a slight increase from the previous report. The agency continued with the reorganization effort during this timeframe; and training activities, time and resources were focused to support the change process. A review of case records for youth ages 14-21 years shows that for those that had some aspect of transition addressed, 90.4% received planning information on health care transition, 92.1% received information on vocations, and 82.6% on community involvement/ integration. Both health care and vocational transition efforts were increased from the previous year. This data reflects only DSCC care coordination efforts in transition planning.

Transition technical assistance site visits were placed on hold during this timeframe due to other agency training priorities. DSCC's training and technical assistance unit did continue to provide transition training to new care coordinators and related technical assistance as requested from DSCC care coordination teams.

Nine DSCC staff participated in the statewide conference held in Effingham, IL. DSCC also supported 16 youth and family members to attend.

Care coordinators continued to encourage youth leadership and participation in the Statewide Independent Living Council of Illinois' Youth with Disabilities Leadership Summit. DSCC again provided a presentation on health care transition for participating youth.

In 2007 DSCC sent surveys to 500 enrolled youth between 14 and 21 years to determine their perceptions of DSCC transition planning efforts and levels of success. Youth and young adults were asked to rate the helpfulness of DSCC assistance including transition materials, a written transition plan, referrals to other agencies, and teaching to use insurance/health benefits from most helpful, very helpful, somewhat helpful to not helpful. The overall rating of DSCC assistance (total responses = 267) when evaluating all assistance categories as a single category

demonstrates 20% indicated DSCC assistance was most helpful, 36% very helpful, and 33% somewhat helpful. DSCC has developed several different tools/materials to assist youth/young adults and their families during the transition process. When asked to rate the helpfulness of transition materials received from DSCC care coordinators on health care skills, school-to-work checklist and employment information in planning for the future, 62 of 67 respondents found these tools helpful.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical transition materials available on website.				X
2. Care coordination staff development on transition.				X
3. Evaluation of transition planning.				X
4. Promoting awareness of transition issues/resources.				X
5. Care coordination related to transition planning for DSCC children and youth.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Some of DSCC's Medical Advisory Board members and administrative staff have met with experts to discuss identifying adult health care providers trained to care for youth/young adults with congenital heart disease to assist with transition to the adult health care system. DSCC approval criteria are under development for Adult Congenital Heart Disease Cardiac Centers. DSCC's staff guidance for staff is being revised to address transition of young adults with congenital heart disease as they move into adult health care systems. Efforts to improve transition from pediatric to adult health care providers for CYSHCN continue through educational trainings, service coordination and facilitation of medical home quality improvement teams.

Training and technical assistance is provided to health care professionals, secondary/post secondary educational partners, youth, families and other stakeholders. DSCC's care coordination teams inform families and assist with coordinating funding to support transition training opportunities. A staff workgroup is reviewing transition materials to determine usefulness and need for revision. A subgroup is giving input on future staff training content. Another workgroup has revised the assessment and Individualized Service Plan process which include transition issues from birth to 21 years.

DSCC supported participation of 21 staff and 28 youth and family members in the statewide transition conference in Peoria, IL.

c. Plan for the Coming Year

A recent chart review found 18.1 percent of youth, aged 14-21, have developed a written DSCC transition plan which is up slightly from 2007 where there were only 16.8 percent with a written plan. Training on developing transition goals with youth and families, recommended by the transition work group, will be implemented starting in July 2009.

DSCC care coordination will strengthen transition efforts for recipients by working to improve

access to high quality, developmentally appropriate, uninterrupted healthcare through facilitating transition to adult health care providers, referring to appropriate resources, providing anticipatory guidance and writing person centered plans. DSCC will continue to collaborate with state and community agency transition partners to strengthen and build community-based infrastructure with regional and state level supports that coordinates the efforts of the health, social, education and employment systems.

The transition work group will continue to evaluate and improve DSCC's transition tools/materials. Feedback from youth, families, and colleagues will be gathered in an effort to continuously evaluate transition service needs and advice on anticipatory guidance, transition tools, resources and training needs. Staff involved in DSCC-sponsored clinics, including the Children's Habilitation Clinic, will develop processes for addressing transition during clinic visits.

State Performance Measure 3: *The proportion of women and children up to 22 years of age who receive appropriate genetic testing, counseling, education and follow-up services*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	1.5	1.5	1.5	1	1
Annual Indicator	1.2	1.0	1.0	1.0	1.3
Numerator	75981	61099	61056	60455	
Denominator	6091399	6091399	6091399	6091399	
Data Source					IDPH, Genetics
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	1	1	1	1	1

Notes - 2008

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2008), Genetics Program.

The 2000 Census estimate were provided by the Genetics Program in 2001 only and have been applied for the trend to the last year 2007.

Since the annual indicators are only reportable data from IDPH, the arbitrary numerator will no longer be estimated in TVIS.

Notes - 2007

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2007), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

A change in data collection procedures resulted in a reduction in this performance measure. A data audit determined that in the past, service providers reported the number of individuals screened rather than the number referred for a genetic condition or concern. Guidelines were refined in an effort to capture the number of clients actually referred rather than merely screened. The performance target was lowered to 1.0 percent to reflect this change in practice. And, although, the performance target was met, the goal was not.

Notes - 2006

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2006), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

a. Last Year's Accomplishments

Illinois did not meet its goal of increasing the proportion of women and children who receive genetic testing, counseling, education, and follow-up services. In fact, due to a change in data collection methods, data were not collected this year regarding laboratory testing received by this population. This is reflected as a decrease in the percentage of women and children receiving services.

The performance target was lowered to 1.0 percent to reflect this change in practice.

The Genetic Counseling and Education program staff provided technical assistance to local health departments, clinical geneticists, and other specialists who received funding. Local health departments received funding for nurses to serve as case managers, facilitators, educators, and referral sources for all clients in need of any service related to genetics. Clinical genetics centers received funding to provide diagnosis, counseling, treatment, and long range management to pediatric and adult patients. Satellite clinics have been staffed by medical geneticists in collaboration with specific local health departments.

Chicago.

In 2008, 911 prenatal clients in the CDPH clinics were screened for genetic disorders. Of these, 76 (11.9 percent) were referred for follow-up. Of those, 61 (80.2 percent) kept their appointments. During FY 2008, the Chicago Department of Public Health received 761 referrals for infants up to one year old for genetic disorders. Public Health nurses made 160 referrals for family counseling and 112 referrals for genetics follow-up. Nine newborns were screened for cystic fibrosis and were referred to a geneticist for follow up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH awards grants to medical centers for diagnostic, counseling and treatment services		X		
2. IDPH awards grants to local health departments for genetic case-finding and referral		X		
3. IDPH awards grants to pediatric hematologists at medical centers		X		
4. IDHFS reimburses for preconceptional risk assessment				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This performance measure is addressed through the routine operation of IDPH's Genetic Counseling program.

IDPH has finalized the development of a Statewide Genetics Plan in 2007. This genetics plan will provide guidance to the Department regarding the future delivery of genetics services over the

next 10 years. Five grants were awarded for the second year to address areas identified through the Plan: public education, professional education, barriers to access to services, finance and reimbursement and ethical, legal and social issues.

Chicago. CDPH Maternal and Family Planning programs routinely screen for genetic disorders in community health clinics, and provide genetics education.

c. Plan for the Coming Year

Local health departments, clinical geneticists, and other specialists will continue to receive funding to provide assessment, counseling, education, and referrals for long-term management of families with a member diagnosed with a genetic condition. IDPH's planned activities are as follows: Clinical genetics centers will provide genetic diagnosis, counseling, treatment, and management to pediatric and adult patients; satellite clinics staffed by medical geneticists and counselors will be on-site at local health agencies; local health departments will provide services related to genetics; use of the Genetic Screening Tool by local health departments will be expanded and this Tool has been integrated into Cornerstone to facilitate use by the local health department staff; specialized services (i.e., Illinois Teratogen Information Service, pediatric metabolic and endocrine clinics, and preconception/prenatal testing and counseling) will be expanded; workshops will be held for professionals, families, and the general public; and IDPH will collaborate with other programs, divisions, and departments in the state to provide comprehensive services to all families in need. With the implementation of newborn screening for cystic fibrosis, additional funding for Genetic Counseling Services has been provided to centers with cystic fibrosis specialists.

Chicago. The CDPH will continue to provide genetic information and referrals as needed, and will offer folic acid to all women receiving prenatal care and family planning services. Licensed genetic counselors will continue to provide genetic counseling to clients referred to them.

State Performance Measure 4: *The prevalence of Early Childhood Caries (ECC)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	32	33	33	33	33
Annual Indicator	33.0	33.0	33.0	30.4	30.4
Numerator	175000	175000	175000		
Denominator	530600	530600	530600		
Data Source					IDPH, Oral Health
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	33	33	33	30	30

Notes - 2008

IDPH, Oral Health has no new data for 2008. After 2010 they may have new data.

Notes - 2007

According to the Oral Health program at IDPH, "ECC prevalence - our Headstart BSS 2006-07 found that at the state level 30.4% of children in Head Start had caries experience." IDPH

continues to report only the percentage to the MCH program. Form 16 has been revised for the 2009 application. Beginning with the 2007 annual report, only the percentage will be reported.

Notes - 2006

Per IDPH, Oral Health section, the figures for 2006 are the same as reported for 2004.

a. Last Year's Accomplishments

In 2001, the IDPH Division of Oral Health (DOH) completed a statewide prevalence study of Early Childhood Caries (ECC) in children participating in the WIC Program. The study found 33 percent of the children presented with ECC. The Division of Oral Health completed a comparable study in 2006.

The IDPH DOH, the IDHS WIC program, and the Head Start programs in Illinois are implementing a statewide oral health education program for women, infants and children participating in the WIC and Head Start programs. The program goal is to improve the oral health status of pregnant women and very young children through oral health education. The educational tools were developed based on a survey of the WIC Program Certified Health Professionals.

The Division and Illinois Chapter of the American Academy of Pediatrics (ICAAP) created a training program to teach pediatricians to apply fluoride varnishes, screen children, provide anticipatory guidance, and refer families to dentists for oral health care. IDPH and ICAAP joined with IDHFS and the UIC College of Dentistry to implement a research project to study the efficiency and efficacy of fluoride varnishes applied by pediatricians in MCH settings.

This pilot initiative is designed to improve oral health status of children by encouraging a focus on oral health screening and anticipatory guidance in primary care practices, as well as promoting a dental home with a dentist for ongoing preventive and needed treatment services. The pilot provides training to physicians in Chicago and the surrounding counties to apply dental varnishes to young children (under age three who have at least four teeth), in the course of regular well-child visits. The project includes an evaluation component to determine its efficacy in improving oral health. The initiative was recently expanded to include Federally Qualified Health Centers (FQHCs) downstate. Based on early provider surveys, this initiative appears to be successful since it appears to be resulting in children getting into dental care earlier and appears to be affecting physician perceptions and focus on oral health, resulting in dental referrals, more attention being paid to dental issues in the primary care setting, and anticipatory guidance.

The Division's Epidemiologist completed the analysis of the 2006 ECC Basic Screening Survey (BSS) of two to four-year-olds in Head Start. The BSS has yielded oral health status of the children as well as a uniform method for ongoing data collection. Preliminary data shows a 30 percent ECC rate in the children screened.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. IDPH works with interested communities to establish community-based prevention programs				X
2. IDHFS supports a pilot test of the application of fluoride varnish	X			
3. IDHFS' contractor, Doral Dental, conducts outreach to All Kids-eligible children who have not received a dental service for 12 months		X		
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH continues to implement the ECC prevention project based on recommendations found in the Illinois Oral Health Plan II (IFLOSS 2007). The program is building oral health infrastructure within MCH programs.

IDPH expanded the training portion of the Program to additional Human Services programs such as Coordinated Child Care and Teen Reach in addition to every WIC, FCM, and Head Start in the state and is providing them incentives of toothbrushes, dental floss, and toothpaste as well as additional oral health educational tools.

The Division is developing an effort to assure that families of children with special health care needs receive the oral health education and referral to dental homes working with DSCC.

A data collection process is in place to complete the annual ECC Basic Screening Survey (BSS) of two to four-year-olds in Head Start. The BSS will yield oral health status of the children as well as a uniform method for ongoing data collection.

The Division has expanded the ECC Prevention Program efforts by funding the creation of an Oral Health Network focusing on the Illinois safety net clinics through the Illinois Primary Health Care Association. The Division has implemented seven community-based ECC Prevention Planning Projects to yield comprehensive community-based plans including outcomes, strategic interventions.

c. Plan for the Coming Year

IDPH will continue to work collaboratively with the MCH programs to assure long-term use of the educational tools. The DOH will continue to expand the ECC Prevention Program into additional MCH programs including those providing child care and support for teen mothers. The Division will review and revise all educational components of the program to assure that children with special health care needs are addressed and included in all aspects of the program.

The Division will expand a partnership with the Illinois Primary Health Care Association to continue to build an Oral Health Network within the IPHCA. The Oral Health Network will assist all oral health safety net clinics and their staff to implement measures aimed at reducing ECC.

The Division will work more closely with community agencies to improve their capacity to implement ECC prevention activities by engaging community partnerships and linking MCH, health and oral health entities. These community projects will use the Illinois Head Start Oral Health Plan and the Head Start program best practices published by the National Oral Health MCH Resource Center.

IDPH will continue to institutionalize a process to collect the oral health status information through the existing Head Start agencies and their dental providers, and distributing a form that will become a standardized tool for all Head Start exams at every Head Start agency to be used every year. The data collection form will be devised using optical scanning technology, precluding the need for data input. IDPH plans to use these data for program evaluation and for annual MCHB reporting.

State Performance Measure 5: *The prevalence of childhood lead poisoning*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	4.8	4.6	2.9	2.8	2.7
Annual Indicator	3.6	3.0	2.3	1.8	1.6
Numerator	9843	8123	6480	5270	4653
Denominator	272757	275103	278078	296998	293297
Data Source					IDPH, CHLPPP
Is the Data Provisional or Final?				Final	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	1.8	1.8	1.8	1.8	1.8

Notes - 2008

Source: Illinois Lead Program provisional data of Chicago and Downstate counts.

Notes - 2007

Source: IDPH, Illinois Lead Program Annual Surveillance Report 2007, Summary Statistics.

Notes - 2006

Source: IDPH, Division of Children's Health & Safety, Childhood Lead Poisoning Prevention Program. Based on available blood lead data for 2006 as of 06/07. These data have been revised during the 2007 annual report. As of 12/07, blood lead tests were reported on 278,078 Illinois children in 2006; 6,480 of those children had at least one blood lead test result greater than or equal to 10 µg/.

a. Last Year's Accomplishments

Rationale. The Healthy People 2010 objective is to eliminate the prevalence of blood lead levels exceeding 10 µg/dL in children aged 1 to 6. Illinois' provisional rate of lead poisoning reported for 2008 is 1.6 percent. Illinois has met this Healthy People 2010 objective.

The program achievements in 2007 include: implementation of a home environmental investigation and a nurse home visit, when a child age thirty-six months and younger has a confirmed blood lead level greater than or equal to 10 µg/dL, as established by the June, 2006 amendment of the Lead Poisoning Prevention Act establishing new guidelines to further expand on lead poisoning prevention efforts in the state; update of the Childhood Lead Risk Assessment Questionnaire and translation of the document into Spanish and French; update of Guidelines for physicians in administering the Childhood Lead Risk Assessment Questionnaire; implemented a study aimed at determining the high risk populations and the increasing percentage of elevated blood lead levels among refugees in Illinois; update of Illinois Lead Program (ILP) web page for increased and easier access to include all lead program educational publications, license training forms and program forms; expansion of the Illinois Childhood Lead Poisoning Elimination Advisory Council to involve an increased number of non-traditional and faith-based organizations; and increased trainings offered to local health department staff and health care providers .

Chicago. Based on 2008 provisional data, 91,171 children aged 0 to 72 months were tested in Chicago. Of those tested, 1,819 children were identified with blood lead levels greater than or equal to 10 µg/dL. High risk neighborhoods have continued to outpace the city as a whole with high prevalence of lead poisoning, even though the numbers of children with elevated blood lead levels are declining. The screening rate among children has remained the same over the last five years. Chicago Department of Public Health (CDPH), focuses testing on children three years of age and younger to identify exposure to paint and non-paint lead hazards. The CDPH strives to assure that those children needing follow-up services receive them by providing follow up blood

lead testing and education. For high risk young children, CDPH conducts public health nurse home visits and home investigations to determine the source of lead poisoning. In 2007, 23,610 children in Chicago had blood lead levels higher than or equal to 5 micrograms per deciliter. As scientific evidence that children's physical and mental development can be affected at blood lead levels of < 10mcg/dl, CDPH strengthened established initiatives, strategic plans and partnerships created to eliminate and/or reduce the impact of lead poisoning on communities. CDPH continues to focus screening efforts on Chicago's high-risk neighborhoods in the south and west sides of the city. Blood lead levels continue to decline at a rate exceeding that of other major cities.

Chicago program achievements in 2008 include: collaboration efforts between CDPH and Environmental Protection Agency to report and prosecute violators of the Lead Based Paint Disclosure Rule, Section 1018. This rule requires the disclosure of known information on lead-based paint and lead-based paint hazards before the sale or lease of most housing built before 1978. CDPH conducts voluntary chart audits to determine the percentage of children testing in high risk area clinics. Evaluation efforts demonstrated a 20 to 25 percent increase in compliance for participating clinics. On the national level, the collaboration with the National Center for Healthy Housing, related to a University of Illinois demolition research study increased the awareness of leaded dust surrounding demolition sites.

Other Chicago program highlights from the past year include: CDPH continues to implement the requirements of the new Illinois Lead Poisoning Prevention Act, passed on June 20, 2006. Working with Action for Children, all childcare providers received information packets about lead poisoning prevention, free lead poisoning prevention training, and information on how and when to provide lead poisoning information to parents enrolled in childcare programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to increase the number of at-risk children screened for lead poisoning	X			
2. Maintain a statewide Lead Elimination Advisory Council				X
3. Maintain local advisory committees				X
4. Continue to coordinate activities with lead hazard reduction grant programs				X
5. Educate pregnant women and families with children under three years of age about lead poisoning through WIC clinics and Perinatal birthing hospitals		X		
6. Train medical residents and nursing students on appropriate clinical management of lead-poisoned children				X
7. Expand efforts with high-risk targeted areas to educate the public about lead poisoning prevention methods, intervention procedures, and safe home renovation practices				X
8.				
9.				
10.				

b. Current Activities

Illinois Lead Program entered into contracts with 80 delegate agencies to provide case management care for lead poisoned children in 89 of the 102 counties. The remaining counties are case managed by the ILP Regional Nurse Consultants.

Quarterly data match reports will be generated following the Interagency Agreement by the

Department of Public Health and the Department of Healthcare and Family Services (HFS) to identify, screen, and provide follow-up services to HFS enrolled children at risk of exposure to lead-bearing substances. HFS intends to make this information available to the provider network for outreach to children who have not been screened or require follow-up based on the screening results.

Chicago: CDPH provides free blood lead testing at WIC sites throughout Chicago's high-risk neighborhoods. Lead Safe Chicago, a strategic plan to increase blood lead screening rates among children, increase awareness among decision makers, identify additional funds and motivate property owners to provide more affordable lead safe housing, continues to contribute to the reduction in lead poisoning in Chicago.

c. Plan for the Coming Year

The ILP data management section is currently working with the Division of Information Technology to replace the current STELLAR (Systematic Tracking of Elevated Lead Levels and Remediation). This system will enhance data collection, monitoring lead levels at the delegate agency level, increase electronic reporting capabilities from laboratories as well as the transmission of reports to the local health departments and the Centers for Disease Control and Prevention (CDC). This program will have a front end mechanism in place to screen and reject reports from laboratories and providers failing to report all criteria requested with in the required data fields. This electronic reporting system should increase the accuracy in reporting to at least 95 percent and greatly reduce the lead reports error file.

The ILP will continue to collaborate with other environmental health programs to increase the education and awareness of health hazards and establish and implement intervention strategies.

The Illinois Lead Program and the Illinois Childhood Lead Poisoning Elimination Advisory Council will continue to meet quarterly to discuss the progress of the strategic lead elimination activities in the state of Illinois.

The ILP will continue oversight of and assistance to the delegate agencies conducting case management and environmental investigation activities in support of their role of targeting and providing services to their high-risk populations.

Chicago. CDPH and community stakeholders will continue the plan to eliminate lead poisoning by 2010 focusing on the four areas: 1) leveraging funds for making housing lead-safe; 2) establishing compliance with lead-safe housing standards; 3) increasing identification of children with elevated lead levels; and 4) enhancing awareness of childhood lead poisoning among decision-makers.

CDPH will continue to conduct data-matches for the state Medicaid agency, conducting direct outreach for Medicaid enrolled children who have not been tested, providing free blood lead testing at WIC sites in high-risk neighborhoods, with screening reviews in doctor's offices.

CDPH will continue to target high-risk neighborhoods in Chicago, providing free blood lead testing at health fairs, centers and home-based daycare centers, community clinics and other locations. The staff will also provide information to parents regarding a medical home and information on All Kids and other programs. The program will continue to provide services to the highest risk young children aged 0-3 years, and to provide lead poisoning prevention.

State Performance Measure 6: *The rate of unintended pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			43.5	43	42.5
Annual Indicator	41.3	42.2	41.7	41.7	41.7
Numerator			70931		
Denominator			170006		
Data Source					IDPH, PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2009	2010	2011	2012	2013
Annual Performance Objective	42	41.5	41	41	41

Notes - 2008

The latest PRAMS data available from the Illinois Department of Public Health are 2006.

Notes - 2007

The latest PRAMS data available from the Illinois Department of Public Health are 2006.

Notes - 2006

The latest PRAMS data available from the Illinois Department of Public Health are 2006. Raw data was provided to IDHS in May 2009 via a data-sharing agreement. Results are also on line at CPONDER -- CDC's PRAMS On-line Data for Epidemiologic Research. The data field is Pregnancy Intention and the indicator is whether mother wanted to become pregnant at time of pregnancy. There were 25 legitimate skips or missing responses.

a. Last Year's Accomplishments

Rationale. This performance measure was added to highlight the rate of unintended pregnancy in Illinois, particularly among Medicaid-eligible women. This health problem was identified through the needs assessment completed for the FFY'06 application. This objective will be addressed through the provision of family planning services through the Title X and School Health Center programs, through the Abstinence Education and Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by the Family Case Management program and Chicago Healthy Start Initiative. It addresses the "direct health care" level of the pyramid and is a "risk factor" service.

Annual performance is measured through Illinois' PRAMS survey. The most recent data available are from 2006. That year, 42 percent of pregnancies resulting in live births were unintended. This is a slight increase from the 2004 report of 41.3 percent. The Healthy People 2010 goal is to increase percent of intended pregnancies to 70 percent. Teens continue to represent the highest proportion of unintended pregnancies when compared to other age groups. Black women represent the highest percent of women with unintended pregnancies (67.5%), as do those who are not married (66.6%). Women whose deliveries are paid for by Medicaid (57.3%) have a rate of unintended pregnancy more than double that of women whose deliveries are paid for by other means (26.3%). There has been no decline in rate of unintended pregnancy in Illinois from 1998-2006.

This performance measure was addressed through the routine operation of the Family Planning program, the School Health Centers, and the Primary and Subsequent Teen Pregnancy Prevention programs. Additionally, two satellite trainings on preconception/interconceptional health were offered in the past year. In June 2008, a satellite training on addressing the Preconception Health Needs of Women was provided and one on Motivational Interviewing was provided in fall of 2008.

Chicago. During 2008, due to data issues with the CERNER computer system, the number of distributed doses of emergency contraception in community health clinics, the percent of

contraception users who received an extended exam to obtain highly effective hormonal contraceptives, and the percent of users choosing hormonal methods are unavailable. Family Planning staff provided 53 outreach educational sessions to 1,417 participants in Chicago communities.

In 2007, the Interconceptional Care Pilot Project provided services to 30 women who have experienced a perinatal death, 70 percent of whom stated these pregnancies were unplanned. Ninety-five percent of these women stated they had plans to delay subsequent pregnancies for one and one-half to two years. In 2007, the CDPH Responsible Fatherhood program began to provide services to males in the Englewood and Uptown communities. That program's approach addresses unintended pregnancy primarily through a peer education and mentoring approach, encouraging men, particularly young men, to assume some responsibility for preventing pregnancy, participate in family planning, and delay fatherhood until they have reached economic stability.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services	X			
2. Provide contraceptive services through School Health Centers	X			
3. Provide education and other youth development interventions to prevent teen pregnancy		X		
4. Provide interconceptional case management		X		
5. Collaborate with IDHFS Illinois Healthy Women program				X
6. IDHFS expands the eligible population upon approval of a federal waiver request				X
7.				
8.				
9.				
10.				

b. Current Activities

The Family Planning program's current activities to reduce the rate of unintended pregnancy include:

1) Offer a broad range of highly effective methods of contraception, including the provision of emergency contraception; 2) Participate in the ongoing promotion, evaluation, and data monitoring of the Illinois Healthy Women Medicaid Waiver; 3) Provide preconception education, including information about the importance of birth planning and spacing; 4) Promote the use of birth control through sexually transmitted disease clinics; 5) Continue efforts to improve awareness of and access to emergency contraception; and 6) Monitor delegate agency outreach education activities to the target population to educate on the prevention of unintended pregnancies.

In June 2009, a satellite training on Male Reproductive Health will be provided. The statewide Preconception/Interconception Care Committee has developed a comprehensive training curriculum on pre/interconceptional health, and began conducting trainings for FCM, WIC, Family Planning and FQHC provider groups in April 2009. The modules will then be posted on the IDHS website along with various tools and handouts as a resource for anyone who wishes to use them.

Chicago. The CDPH addresses unintended pregnancy through Family Planning, Male Responsibility, and Healthy Start programs. The Interconceptional Care Pilot Project continues to visit at-risk women and provide counseling and education on interconceptional care.

c. Plan for the Coming Year

The Department will address unintended pregnancy through the routine operation of the Family Planning and School Health Center programs, the Abstinence-Only Education, Teen Pregnancy Prevention Programs (both Primary and Subsequent) and by providing interconceptional care through the Family Case Management program and the Chicago Healthy Start Initiative.

Chicago. CDPH will continue to address unintended pregnancy through Family Planning, Male Responsibility, Healthy Start, Responsible Fatherhood, and the Interconceptional Care Pilot Project. The Interconceptional Care Pilot Project manager plans to develop a continuing education online course for CDPG staff, and provide at least two additional trainings to FCM sites on interconceptional care and services.

State Performance Measure 9: *The proportion of children under 36 months of age in WIC or FCM who have received at least one developmental screening test in the previous 12 months*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			63	66	66.5
Annual Indicator	56.9	60.6	64.4	66.1	66.1
Numerator	28040	28901	29775	33248	34772
Denominator	49251	47671	46200	50302	52595
Data Source					IDHS, Cornerstone
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	67	68	69	71	71

Notes - 2008

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2009.

Notes - 2007

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2008.

Notes - 2006

Source: Illinois Department of Human Services, Community Health and Prevention, Cornerstone Q1, SFY2007.

a. Last Year's Accomplishments

Rationale. This performance measure was selected because the expert panel on child and adolescent health for the FFY'06 needs assessment recommended that the Department address the mental health needs of children through the MCH program. This performance measure highlights the unique role that the MCH program can play in identifying children who are experiencing developmental delays and ensuring that they have access to appropriate treatment. This performance measure is classified at the enabling level of the pyramid and as a "risk factor" service.

The Department monitors performance on this measure each quarter. In FY08, 80.8 percent of infants had at least one developmental screening by 12 months of age and 58.8 percent had two or more by age 24 months. Altogether, 66.1 percent of children less than 36 months of age inWIC or FCM had received at least one developmental screening in the previous 12 months as

of FY2008. This measure has registered continuous improvement since 2004 when the proportion was 57 percent.

This year's goal was 80 percent of one year olds will be tested for developmental delay by their first birthday and 80 percent of 2 year olds will have six or more developmental screenings before their 2nd birthday.

Chicago. In FY 2008, 8,481 CDPH children age birth to 36 months received developmental screenings. Forty-three of these were abnormal and the children were referred for follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct developmental screening through the WIC and Family Case Management programs		X		
2. Conduct developmental screening through the Healthy Families Illinois, Parents Too Soon, and Teen Parent Services programs		X		
3. Provide additional training on early childhood development to Family Case Management, WIC, Healthy Families Illinois, Parents Too Soon, and Teen Parent Services providers through the State Early Childhood Comprehensive Systems initiative				X
4. Refer children who appear to have a developmental delay to the Part C Early Intervention program for further assessment		X		
5. The All Our Kids Early Childhood Networks will coordinate or promote developmental screening in the communities they serve				X
6. The MCH program will participate in the Early Learning Council and the Early Childhood Committee of the Illinois Children's Mental Health Partnership				X
7. IDHFS leads the Assuring Better Child Development II and Enhancing Developmentally-Oriented Primary Care projects				X
8.				
9.				
10.				

b. Current Activities

The FCM program implemented a new policy for developmental screening. This new policy provided for:

- Developmental screenings on infants and children between 3 and 66 months
- An approved tool is to be used
- A licensed individual (R.N., Nutritionist, Social Worker or individuals with advanced degrees in child health) is to perform the screening
- Make appropriate referrals to Early Intervention
- Follow-up to ensure referral was successful

IDHS partnered with staff from the EDOPC project in FY2008 to provide comprehensive training on child development issues to an array of providers across the state.

Local WIC agencies refer families to the Early Intervention Program as needed. Follow-up is documented in case notes. In February 2008, approximately 40 EI Managers were provided an update on the WIC Program to ensure consistent messages and referrals are made.

Chicago. CDPH FCM staff administers the Denver Developmental Screening Test, and verifies receipt of other developmental screening. Other CDPH programs that monitor and facilitate receipt of developmental screenings include WIC, the Greater Westside of Chicago Early Childhood Network, and the greater Englewood Healthy Start Initiative.

c. Plan for the Coming Year

This performance measure will be addressed through the routine operation of the WIC and FCM programs. IDHS already measures the occurrence of developmental screening each quarter as a performance measure in the WIC and FCM programs. All of the local agencies that provide these services received training during FFY'05 in the use of the Ages and Stages Questionnaire Social and Emotional development scale, and many local program staffs have already been trained to use other developmental screening tests. Children who show evidence of developmental delay will be referred to the Part C Early Intervention program.

The EDOPC training project will continue, and will be offered to IDHS Child Care Nurse Consultants in FY2010, so they can train licensed day care providers. It also will be offered to members of the AOK networks.

Chicago.

CDPH programs will continue to perform developmental screenings, and monitor and facilitate receipt of screenings performed by other providers. Healthy Start case managers will perform developmental screening on at least 80 percent of enrolled children.

State Performance Measure 10: *Females 15 to 24 years of age receiving services at Title X family planning clinics tested at least once for chlamydia*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				57	58
Annual Indicator		55.9	55.1	55.9	52.1
Numerator		47645	43503	41040	38456
Denominator		85178	78908	73478	73749
Data Source					IDPH & IDHS Family Planning
Is the Data Provisional or Final?				Final	Final
	2009	2010	2011	2012	2013
Annual Performance Objective	59	60	61	61	61

Notes - 2008

Source: 2008 FPAR

Notes - 2007

This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2007 FPAR

Notes - 2006

This is a new state performance measure being introduced before the end of the needs assessment cycle. Therefore the Annual Performance Objective technically may not be

measured until the 2007 annual report. The measure will indicate performance of the Family Planning program in collaboration with the STD Section at IDPH for identifying and treating chlamydia among young females. Source: 2006 FPAR

a. Last Year's Accomplishments

The Title X Family Planning Program partners with the IDPH STD program to reduce the prevalence of sexually transmitted diseases and prevent long-term genitourinary complications. In 2008, IDPH reported that 52.1 percent of females less than 25 years of age receiving services at Title X Family Planning Clinics received at least one test for Chlamydia.

Accomplishments in FY'07 directed to testing individuals most at risk of Chlamydia include:

- IDPH reported that the number of Chlamydia tests submitted decreased and the positivity rate increased, indicating that clients are being appropriately targeted for testing. Efforts to reduce testing in females 25 years of age and older with no identified risk factors are ongoing, and have contributed to the decrease in testing.
- Family Planning and SHCs increased testing among males, prompted by the availability of urine screening.
- IDPH/IDHS Family Planning Program encouraged and monitored adherence to the screening criteria at family planning clinics, resulting in a decrease in the number of tests and an increase in the positivity rate.
- Testing volume from SHCs increased significantly, because of the addition of new sites to the screening program, availability of testing at IDPH laboratories, and training provided to SHC staff on counseling and sex partner notification.

Chicago. The CDPH Office of STD Surveillance reports on residents of Chicago between 15 -- 25 with Chlamydia: 15,536 persons for 2003; 14,135 persons for 2004; 15,239 persons for 2005, and 15,524 persons for 2006. Non-Hispanic Blacks are disproportionately impacted by Chlamydia. In 2006, 11,077 (71.4 percent) of cases among Non-Hispanic Blacks were reported, compared to 1,320 cases among Hispanics, and 407 cases among Non-Hispanic Whites.

A pilot project between CDPH's STDS/HIV/AIDS Division Adolescent Program and Chicago Public Schools (CPS) provided STD/HIV information and testing to all juniors and seniors at two high schools. Sixteen percent of the students involved tested positive for Chlamydia.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Family Planning services	X			
2. Provide STI testing and treatment through School Health Centers	X			
3. Collaborate with the IDPH Sexually Transmitted Disease Program and AIDS Activity Section				X
4. Participate in the Region V and Illinois Infertility Prevention Projects				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Family Planning (FP) Program and the IDPH STD program are continuing to encourage and monitor the age-based screening criteria for Chlamydia. A mailing was sent by IDPH-STD to each Title X FP Clinic to provide screening recommendations and site-specific data on screening

coverage rates by age group for 2008. During a required Family Planning Program training, Illinois STI rates and screening criteria will be presented. The delegates will continue to receive a list of the percent of clients less than 26 years of age who received Chlamydia and Gonorrhea testing and timeliness of treatment data.

Chicago. CDPH policy mandates all pregnant women should be screened at least once during their pregnancy. CDPH's STD/HIV/AIDS Division Adolescent Program and HIV Counseling and Testing unit are currently meeting with key CPS staff to revise CPS's confidentiality and Sexually Transmitted Infection (STI) policy/procedures/protocol. The revised policy/protocol will allow STI counseling and testing to occur in all high schools whether or not there is a school based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago (providing a STD/HIV Health Education curriculum to approximately 130 youth housed in the facility) and with the YMCA.

c. Plan for the Coming Year

The Department will increase the screening coverage of young women receiving services at Title X Family Planning Clinics by continuing to adhere to the age-based screening criteria for Chlamydia. The Family Planning program and the IDPH STD program will undertake the following activities in FY'09 to reduce the rate of Chlamydia infection:

Testing all clients less than 26 years of age including clients seeking pregnancy testing.

Retesting persons with positive tests three months after treatment to detect reinfection.

Provide testing of partners of family planning clients with positive test results.

Initiating Expedited Partner Therapy when proposed legislation becomes law in Illinois.

Retesting persons with positive tests: Continue to guide a project of retesting individuals with positive Chlamydia as presented in CDC's 2002 STD Screening and Treatment Guidelines.

Chicago. The Healthy Start and Family Planning programs will continue to provide STD education, and all CDPH pregnant women will be screened at least once during their pregnancy. The CDPH STD/HIV/AIDS Division Adolescent Program and CPS are planning to extend STD/HIV information and testing to all juniors and seniors within all high schools. CDPH is currently looking to hire a Director of School Health (who would report jointly to CDPH Commissioner Dr. Terry Mason and Mr. Arne Duncan, Chief Executive Officer of CPS.) The Adolescent program will continue to provide services to youth at the Cook County Juvenile Temporary Detention Center and the Illinois Youth Center-Chicago, and will continue to collaborate with community-based organizations and alternative and charter schools.

E. Health Status Indicators

Introduction

Data for Health Systems Capacity Indicators 1 through 9 are presented on Forms 17, 18, and 19.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
---------------------------------------	------	------	------	------	------

Annual Indicator	8.4	8.6	8.6	8.5	8.5
Numerator	15230	15296	15607	15370	
Denominator	180665	178872	180503	180530	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 data are not available at this time. There is no timeframe for availability of these data.

The estimate is provisional and is the same value as reported for year FY2007.

Notes - 2007

Source: Final release from IDPH, Center for Health Statistics.

Notes - 2006

Data Source: IDPH Center for Health Statistics.

Narrative:

The percent of live births weighing less than 2,500 grams has remained stable fluctuating by a 10th of a percent year after year since 2004. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: Nutrition Program for Women, Infants and Children (WIC) and FCM. IDHS, IDHFS, and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which provides performance incentives for outreach and enrollment of high-risk pregnant women into high-risk case management programs in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Family Planning and IDHFS' IHW programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004. A renewal application for an additional three years was submitted to CMS in October 2008. As of June 2009, IDHFS received a 60 day extension (August 31, 2009) to the IHW waiver. CMS is processing the three-year renewal request. Informal feedback from initial reviews is positive. The delays in processing is attributed to the transition of administrations at the federal level. IDHFS anticipates receiving approval of the renewal with the extension period.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
---------------------------------------	------	------	------	------	------

Annual Indicator	6.4	6.6	6.7	6.5	6.5
Numerator	11182	11360	11619	11345	
Denominator	173659	172105	173860	173787	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 data are not available at this time. There is no timeframe for availability of these data.

The estimate is provisional and is the same value as reported for year FY2007.

Notes - 2007

Source: Final release from IDPH, Center for Health Statistics.

Notes - 2006

Data Source: Illinois Department of Public Health, Center for Health Statistics.

Narrative:

The percent of live births weighing less than 2,500 grams has remained stable fluctuating by a 10th of a percent year after year since 2004. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: Nutrition Program for Women, Infants and Children (WIC) and FCM. IDHS, IDHFS, and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which provides performance incentives for outreach and enrollment of high-risk pregnant women into high-risk case management programs in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Family Planning and IDHFS' IHW programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004. A renewal application for an additional three years was submitted to CMS in October 2008. As of June 2009, IDHFS received a 60 day extension (August 31, 2009) to the IHW waiver. CMS is processing the three-year renewal request. Informal feedback from initial reviews is positive. The delays in processing is attributed to the transition of administrations at the federal level. IDHFS anticipates receiving approval of the renewal with the extension period.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.7	1.6	1.6	1.6	1.6

Numerator	3024	2932	2964	2938	
Denominator	180665	178872	180503	180530	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 data are not available at this time. There is no timeframe for availability of these data.

The estimate is provisional and is the same value as reported for year FY2007.

Notes - 2007

Source: Final release from IDPH, Center for Health Statistics.

Notes - 2006

Data Source: Illinois Department of Public Health, Center for Health Statistics.

Narrative:

The percent of live births weighing less than 1,500 grams has remained stable since 2005. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: Nutrition Program for Women, Infants and Children (WIC) and FCM. IDHS, IDHFS, and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which provides performance incentives for outreach and enrollment of high-risk pregnant women into high-risk case management programs in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Family Planning and IDHFS' IHW programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004. A renewal application for an additional three years was submitted to CMS in October 2008. As of June 2009, IDHFS received a 60 day extension (August 31, 2009) to the IHW waiver. CMS is processing the three-year renewal request. Informal feedback from initial reviews is positive. The delays in processing is attributed to the transition of administrations at the federal level. IDHFS anticipates receiving approval of the renewal with the extension period.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.2	1.2	1.2	1.2	1.2

Numerator	2095	2088	2167	2072	
Denominator	173659	172105	173860	173787	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2008 data are not available at this time. There is no timeframe for availability of these data.

The estimate is provisional and is the same value as reported for year FY2007.

Notes - 2007

The 2007 data were not available at the time the 2009 application was submitted. There is no timeframe for availability of these data.

TVIS requires an estimate; therefore the estimate is provisional and is the same value as reported for year CY2006.

Notes - 2006

Data Source: Illinois Department of Public Health, Center for Health Statistics.

Narrative:

The percent of live births weighing less than 1,500 grams has remained stable since 2004. The DHS and its partners have instituted several initiatives to lower this rate. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the CDPH and, on a limited basis, through the FCM program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: Nutrition Program for Women, Infants and Children (WIC) and FCM. IDHS, IDHFS, and several private foundations have worked together to develop and implement Healthy Births for Healthy Communities, which provides performance incentives for outreach and enrollment of high-risk pregnant women into high-risk case management programs in two Chicago Community Areas. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Family Planning and IDHFS' IHW programs are the state's primary strategies for improving preconceptional health. The Family Planning program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted infections. Services are available statewide through a network of delegate agencies. IHW was implemented as a five-year waiver in April 2004. A renewal application for an additional three years was submitted to CMS in October 2008. As of June 2009, IDHFS received a 60 day extension (August 31, 2009) to the IHW waiver. CMS is processing the three-year renewal request. Informal feedback from initial reviews is positive. The delays in processing is attributed to the transition of administrations at the federal level. IDHFS anticipates receiving approval of the renewal with the extension period.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	6.0	5.7	6.9	6.9	6.9
Numerator	154	147	181		
Denominator	2574966	2566155	2640114		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Source: The Center for Health Statistics, IDPH, has not released a death rate for this age group since reporting year 2006.

Notes - 2007

The 2007 data were not available at the time the 2009 application was submitted. There is no timeframe for availability of these data.

TVIS requires an estimate; therefore the estimate is provisional and is the same value as reported for year FY2006.

Notes - 2006

Source: IDPH death data and Census 2006 population estimates.

Narrative:

The number of deaths to children aged 14 years and younger increased in 2006; there were 34 more deaths for a rate of 6.9 per 100,000.

Home visiting is an effective invention in preventing unintentional and intentional injuries to young children. During the visit health professionals review safety practices with parents or care-takers of the child. Illinois administers several home visiting programs the newest of which is Strong Foundations.

IDHS, DCFS and ISBE are working together to develop the state's infrastructure to support evidence-based home visiting programs. These three agencies provide program grants to support three different approaches to home visiting for the purpose of supporting families and reducing the risk of child maltreatment. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The three agencies are working with the Home Visiting Task Force, a broad-based advisory group of service providers, advocates and parents established by the Early Learning Council. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment."

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	2.4	2.0	2.1	2.0	2
Numerator	64	56	58	54	
Denominator	2699740	2752100	2720397	2643433	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

The latest data available from IDOT Annual Reports is 2007. The Annual Indicator for 2007 is being reported again in 2008.

Notes - 2007

Source: 2007 Annual Report, Illinois Crash Facts & Statistics, IDOT. The numerator includes drivers, passengers, pedestrians, pedalcyclists on public roadways. IDPH is the final data source.

Notes - 2006

Source: IDPH, Center for Health Statistics. IDOT records deaths that occur on public roadways, an important difference from the final deaths released from IDPH registrars.

Narrative:

Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2.0 per 100,000 children. Actual performance was 2.0 per 100,000 in 2008, the most recent data available.

The Department continued its partnership with the city of Chicago Police Department, the Illinois State Police, local hospitals and health centers, and the IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and over 3,000 car seats were checked for proper seat installation. During a car seat check we show clients how to properly use seat belts as well as proper car seat installation.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	18.9	20.7	17.6	18.8	18.8
Numerator	344	379	328	347	
Denominator	1822891	1829459	1866573	1847996	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

The 2007 Annual Indicator is again being reported in 2008.

Notes - 2007

Source: 2007 Annual Report, Illinois Crash Facts & Statistics, IDOT. The numerator includes drivers, passengers, pedestrians, pedalcyclists on public roadways.

Notes - 2006

Source: 2006 Annual Report, "Illinois Crash Facts & Statistics", IDOT. Includes drivers, passengers, pedestrians, pedalcyclists on public roadways.

Narrative:

The number of deaths from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years increased by 19 from 2006 to 2007. While not a large number, these deaths resulted in many years of potential life lost.

One significant factor associated with motor vehicle crashes among this age cohort is alcohol consumption. DHS is administering a SAMHSA Statewide Incentive Grant, Strategic Prevention Framework, which is addressing underaged drinking as well as alcohol use among young adults in 15 community areas throughout Illinois. The communities utilize an array of prevention techniques to reduce alcohol consumption.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	345.9	334.3	318.4	323.5	321.7
Numerator	9339	9028	8662	8552	8467
Denominator	2700253	2700253	2720397	2643433	2632062
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

The number of non-fatal injuries is hospital discharge data. The addition of additional diagnoses codes in 2008 only added a small percentage more than using the previous method of reporting.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2008 Illinois Population Estimates, U.S. Census Bureau.

Notes - 2007

The number of non-fatal injuries is hospital discharge data.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2007 Illinois Population Estimates, U.S. Census Bureau.

Notes - 2006

The number of non-fatal injuries is hospital discharge data.

Sources: IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2006 Illinois Population Estimates, U.S. Census Bureau. (Revised 9/5/08)

Narrative:

The rate of non-fatal injuries among children aged 14 years and younger increased slightly in 2007 and is projected to be at level in 2008.

Home visiting is an effective invention in preventing unintentional and intentional injuries to young children. During the visit health professionals review safety practices with parents or care-takers of the child. Illinois administers several home visiting programs the newest of which is Strong Foundations.

IDHS, DCFS and ISBE are working together to develop the state's infrastructure to support evidence-based home visiting programs. These three agencies provide program grants to support three different approaches to home visiting for the purpose of supporting families and reducing the risk of child maltreatment. The approaches are: Healthy Families Illinois, Parents as Teachers and the Nurse-Family Partnership. The three agencies are working with the Home Visiting Task Force, a broad-based advisory group of service providers, advocates and parents established by the Early Learning Council. The project, called "Strong Foundations," is supported by a cooperative agreement from the federal Children's Bureau for "Supporting Evidence-Based Home Visitation Programs to Prevent Child Maltreatment."

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	21.1	19.5	17.4	14.9	18.7
Numerator	571	526	472	393	492
Denominator	2700253	2700253	2720397	2643433	2632062
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Notes - 2007

IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2007 Illinois population estimates, US Census Bureau.

Notes - 2006

IDPH, Office of Policy, Planning and Statistics, Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau.

Narrative:

The rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger increased by 25 percent between 2007 and 2008. According to IDPH, the agency that maintains the Hospital Discharge Survey which is the source of the statistics, the adoption of e-codes advanced significantly during this time frame resulting in a more accurate counting of injuries.

The Department continued its partnership with the city of Chicago Police Department, the Illinois State Police, local hospitals and health centers, and the IDCFS to conduct community child safety seat checks. Through this partnership, 45 safety seat checks were held, and 1,400 car safety seats were distributed to low-income families, and over 3,000 car seats were checked for proper seat installation. During a car seat check we show clients how to properly use seat belts as well as proper car seat installation.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	87.1	86.0	86.0	74.0	82.0
Numerator	1566	1573	1605	1367	1525
Denominator	1798262	1829459	1866573	1847996	1858677
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

The number of non fatal injuries is hospital discharge data that were made final and available in 2009. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2008 Illinois population estimates, US Census Bureau.

Notes - 2007

The number of non fatal injuries is hospital discharge data that were made final and available in 2008. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2007 Illinois population estimates, US Census Bureau.

Notes - 2006

The number of non fatal injuries is hospital discharge data that were made final and available in 2007. Sources: IDPH Division of Health Policy, Facility Discharge Data. 2006 Illinois population estimates, US Census Bureau.

Narrative:

The rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years increased by from 2007 to 2008. According to IDPH, the agency that maintains the Hospital Discharge Survey which is the source of the statistics, the adoption of e-codes advanced significantly during this time frame resulting in a more accurate counting of injuries.

One significant factor associated with motor vehicle crashes among this age cohort is alcohol consumption. DHS is administering a SAMHSA Statewide Incentive Grant, Strategic Prevention Framework, which is addressing underaged drinking as well as alcohol use among young adults in 15 community areas throughout Illinois. The communities utilize an array of prevention techniques to reduce alcohol consumption.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	30.3	32.8	33.2	34.8	36.7
Numerator	13180	14273	14889	15736	16769
Denominator	435581	435581	448529	452277	457329
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: IDPH, STD Section, and 2008 Census Estimates.

Notes - 2007

Source: IDPH, STD Section, and 2007 Census Estimates.

Notes - 2006

Source: IDPH, STD Section - 2006 data is final. The denominator is from 2005 Census population estimates available from: www.census.gov/popest/states/asrh/files/

Narrative:

The Family Planning (FP) Program and the IDPH STD program are continuing to encourage and monitor the age-based screening criteria for Chlamydia. A mailing was sent by IDPH-STD to each Title X FP Clinic to provide screening recommendations and site-specific data on screening coverage rates by age group for 2008. During a required Family Planning Program training, Illinois STI rates and screening criteria will be presented. The delegates will continue to receive a list of the percent of clients less than 26 years of age who received Chlamydia and Gonorrhea testing and timeliness of treatment data.

Chicago. CDPH policy mandates all pregnant women should be screened at least once during

their pregnancy. CDPH's STD/HIV/AIDS Division Adolescent Program and HIV Counseling and Testing unit are currently meeting with key CPS staff to revise CPS's confidentiality and Sexually Transmitted Infection (STI) policy/procedures/protocol. The revised policy/protocol will allow STI counseling and testing to occur in all high schools whether or not there is a school based health clinic. The adolescent program also re-established collaborations with the Illinois Youth Center-Chicago (providing a STD/HIV Health Education curriculum to approximately 130 youth housed in the facility) and with the YMCA.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.6	9.9	10.3	10.5	11.4
Numerator	21946	22551	23561	23405	25394
Denominator	2276242	2276242	2279673	2232895	2232895
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

Source: IDPH STD Section, December 2008.

Notes - 2007

Source: IDPH STD Section, December 2007. Possible error on the webpage claiming that 2007 data are provisional when the 2008 data are final.

Notes - 2006

Source: IDPH, STD Section - 2006 data is final. The denominator is from 2006 Census population estimates available from: www.census.gov/popest/states/asrh/files/

Narrative:

The rate of women aged 20 through 44 years with a reported case chlamydia is steadily increasing. The statistics also represent a greater availability of screening opportunities.

The Family Planning program and the IDPH STD program undertake the following activities to reduce the rate of Chlamydia infection:

Testing all clients seeking pregnancy testing.

Retesting persons with positive tests three months after treatment to detect reinfection.

Provide testing of partners of family planning clients with positive test results.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	185298	139452	30663	1047	8468	217	5451	0
Children 1 through 4	529115	399977	87531	1714	23912	318	15663	0
Children 5 through 9	690762	523485	117693	2645	27829	525	18585	0
Children 10 through 14	702567	528299	130061	2802	25890	610	14905	0
Children 15 through 19	759395	575268	140425	3072	27573	690	12367	0
Children 20 through 24	813542	563967	179931	4931	47955	1091	15667	0
Children 0 through 24	3680679	2730448	686304	16211	161627	3451	82638	0

Notes - 2010

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Source: 2008 Official Illinois Population Estimates, Census Bureau. All races equal 100%.

Narrative:

The distribution of children by racial category indicates that Caucasian children comprise the largest proportion of Illinois population at 74 percent. Other racial categories represent 19 percent (African Americans), .4 percent (American Indian), 4 percent (Asian), .09 (Native Hawaiian) and 2 percent (more than one race).

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	136913	48385	0
Children 1 through 4	398888	130227	0
Children 5 through 9	534838	155924	0
Children 10 through 14	564838	137729	0

Children 15 through 19	632502	126893	0
Children 20 through 24	601963	211579	0
Children 0 through 24	2869942	810737	0

Notes - 2010

Narrative:

Because a large segment of Illinois' population is of Hispanic/Latino descent and continue to communicate in Spanish, state programs are obliged to present promotional, educational and service information in Spanish. Translation activities are in place for other large ethnic enclaves, e.g. Polish-Americans.

Health Status Indicators 07A: Live births to women (of all ages) enumerated by maternal age and race. (Demographics)

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	260	111	149	0	0	0	0	0
Women 15 through 17	5988	3479	2452	13	26	1	0	17
Women 18 through 19	12066	7660	4259	23	84	1	0	39
Women 20 through 34	134324	104417	21928	203	7298	26	0	452
Women 35 or older	27892	22529	3008	31	2196	1	0	127
Women of all ages	180530	138196	31796	270	9604	29	0	635

Notes - 2010

Source: IDPH, Center for Health Statistics, 2007 Natality. The age-specific counts in "Other and Unknown" are other. The Unknown has been counted in Women aged 35+ so that the birth total is correct.

Narrative:

Live births by maternal age and race are presented for 2007 (the latest natality data for Illinois).

Health Status Indicators 07B: Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	181	79	0
Women 15 through 17	3920	2068	0
Women 18 through	8513	3553	0

19			
Women 20 through 34	101024	33300	0
Women 35 or older	22806	5086	15
Women of all ages	136444	44086	15

Notes - 2010

Source: IDPH, Center for Health Statistics, 2007 Natality. The age-specific counts in "Other and Unknown" are other. The Unknown ethnicity has been counted in Women aged 35+ so that the birth total is correct.

Narrative:

Live births by maternal age and Hispanic ethnicity are presented for 2007 (the latest natality data for Illinois).

Health Status Indicators 08A: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1343	841	452	7	33	0	0	10
Children 1 through 4	174	112	59	0	1	0	0	2
Children 5 through 9	98	66	30	0	2	0	0	0
Children 10 through 14	121	73	45	0	3	0	0	0
Children 15 through 19	549	377	161	1	8	0	0	2
Children 20 through 24	772	493	263	0	10	0	0	6
Children 0 through 24	3057	1962	1010	8	57	0	0	20

Notes - 2010

Narrative:

The number of deaths to children ages 0 to 24 are presented by age and race subgroups for 2006, the latest available mortality data in Illinois.

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1023	292	28

Children 1 through 4	132	37	5
Children 5 through 9	77	20	1
Children 10 through 14	100	21	0
Children 15 through 19	446	98	5
Children 20 through 24	674	86	51
Children 0 through 24	2452	554	90

Notes - 2010

Narrative:

The number of deaths to children 0 to 24 years of age are presented by age and Hispanic ethnicity for 2006, the latest mortality data available in Illinois.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	3574275	2699997	644417	12259	137824	2638	77140	0	2008
Percent in household headed by single parent	17.3	12.6	38.7	14.5	11.4	18.2	23.8	28.6	2008
Percent in TANF (Grant) families	1.4	0.3	5.0	0.1	0.4	3.7	0.1	0.0	2008
Number enrolled in Medicaid	1456956	524628	458606	2053	35613	0	106998	329058	2008
Number enrolled in SCHIP	69597	33004	6008	360	2482	0	8346	19397	2008
Number living in foster home care	16726	5535	9827	22	30	0	1004	308	2008
Number enrolled in food stamp program	717917	259662	323768	523	14862	1047	747	117308	2008
Number enrolled in WIC	401718	209420	104837	726	7917	0	0	78818	2008
Rate (per 100,000) of juvenile crime arrests	1699.1	929.8	5428.6	212.1	215.5	0.0	0.0	0.0	2008
Percentage of high	4.4	2.2	9.0	3.7	1.6	1.6	3.9	0.0	2008

school drop-outs (grade 9 through 12)									
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Notes - 2010

Source: 2007 Population Estimates, U.S. Census Bureau.

Census Source: B11001. HOUSEHOLD TYPE (INCLUDING LIVING ALONE) - Universe: HOUSEHOLDS

Data Set: 2007 American Community Survey -- 1-Year Estimates

Survey: 2007 American Community Survey

TANF Source: ILLINOIS DEPARTMENT OF HUMAN SERVICES

Bureau of Research and Analysis

Race/Ethnicity Counts of Persons Aged 0-19

As of 03/2009

Schedule 9

(This Form represents the population of children. The percents for this row's entry are of ages 0-19.)

(Percent of Total TANF count of 48,359 children is 5 percent for Unknown race. The African American percent total is 66.3% and the White percent total is 18.3%)

Source: HFS, hand written updates on Form 21 form, source report unknown. Need to report Hispanic in "more than one race" as we need to report Hispanic somewhere to TOTAL in Part A. HFS continues to report Pacific Islander with Asian.

Source: HFS, hand written updates on Form 21 form, source report unknown. Need to report Hispanic in "more than one race" as we need to report Hispanic somewhere to TOTAL in Part A. HFS continues to report Pacific Islander with Asian.

Source: IDHS, Bureau of Food Stamp Accuracy and Quality Control, Number of 0-19 Year Olds Receiving Food Stamps - Statewide, Organized by Race and Ethnicity, March 2009. Other and Unknown were reported separately (73,895 Other and 43,413 Unknown).

Source: ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES
WARDS AGE 0-19 ON LAST DAY OF FISCAL YEAR 2008 - BY AGE AND RACE; DATA AS OF 04/17/09. Hispanic is considered race in this report and has been added in the total under "More than one race reported".

(Asian and Pacific Islander are combined.)

Narrative:

Infants and children aged 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are presented.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific
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Miscellaneous Data BY HISPANIC ETHNICITY	Hispanic or Latino	Hispanic or Latino	Reported	Reporting Year
All children 0 through 19	2844256	730019	0	2008
Percent in household headed by single parent	12.1	26.4	0.0	2008
Percent in TANF (Grant) families	1.7	0.8	0.0	2008
Number enrolled in Medicaid	1349958	106998	0	2008
Number enrolled in SCHIP	61251	8346	0	2008
Number living in foster home care	15722	1004	0	2008
Number enrolled in food stamp program	567181	107322	43413	2008
Number enrolled in WIC	241134	160467	117	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	1699.1	2008
Percentage of high school drop-outs (grade 9 through 12)	4.4	7.2	0.0	2008

Notes - 2010

HFS continues to aggregate Hispanic to one value. It is unknown how many White Hispanic children are served by HFS, for example.

Narrative:

Infants and children 0 to 19 years of age in miscellaneous situations or enrolled in various state programs are arrayed here by Hispanic ethnicity.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	3162133
Living in urban areas	3560626
Living in rural areas	13649
Living in frontier areas	0
Total - all children 0 through 19	3574275

Notes - 2010

Source: US Department of Agriculture, 2007 Rural-Urban Continuum Codes.

Source: US Department of Agriculture, 2007 Rural-Urban Continuum Codes.

The number of children living in 'urban' areas is 398,493. Total urban is Metropolitan plus Urban for purposes of entry to this form.

Source: US Department of Agriculture, 2007 Rural-Urban Continuum Codes.

Narrative:

Geographic living area for all children aged 0 through 19 years is primarily urban.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	12852548.0
Percent Below: 50% of poverty	5.2
100% of poverty	11.6
200% of poverty	29.3

Notes - 2010

Source: The 2007 American Community Survey; the 2007 Consumer Population Survey (Poverty 46-Part 100125_4) Annual Social & Economic Supplement does not supply any data to calculate the proportion below 50 percent of FPL.

The CPS estimate for the total state is 12,633,000 and at 100% FPL is 10.6 and percentage at 200 is 27.1. The CPS estimate for children aged 0-17 in poverty is 3,126,000 and at 100% FPL is 14.2% and at 200 is 35.8.

For the purposes of this form in creating levels of poverty for the select MCH population, the official 2007 Population Estimate from the Census Bureau are incorporated along with the C17024 ACS ratios of poverty below 50, 100, and at 200. The official estimates for Illinois is 12,852,548 and 3,574,275 for children aged 0-19. The ACS poverty estimate for the state is 12,541,198 and 3,157,879 for children aged 0-17.

The ACS calculation for the 3 breakouts require the addition of the population numbers at the ratio levels of under 0.50, plus 0.50 to 0.99, plus 1.00 to 1.24, plus 1.25 to 1.99. The percent calculations have been extrapolated to the 2007 population estimate for the total population of the state and for children aged 0-19.

Narrative:

Various poverty levels are presented. Almost a third of Illinois' population is at or below 200 percent of poverty.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	3574275.0
Percent Below: 50% of poverty	6.6
100% of poverty	14.7
200% of poverty	38.8

Notes - 2010

Source: The 2007 American Community Survey; the 2007 Consumer Population Survey (Poverty 46-Part 100125_4) Annual Social & Economic Supplement does not supply any data to calculate the proportion below 50 percent of FPL.

The CPS estimate for the total state is 12,633,000 and at 100% FPL is 10.6 and percentage at 200 is 27.1. The CPS estimate for children aged 0-17 in poverty is 3,126,000 and at 100% FPL is 14.2% and at 200 is 35.8.

For the purposes of this form in creating levels of poverty for the select MCH population, the official 2007 Population Estimate from the Census Bureau are incorporated along with the C17024 ACS ratios of poverty below 50, 100, and at 200. The official estimates for Illinois are 12,852,548 and 3,574,275 for children aged 0-19. The ACS poverty estimates for the state are 12,541,198 and 3,157,879 for children aged 0-17.

The ACS calculation for the 3 breakouts require the addition of the population numbers at the ratio levels of under 0.50, plus 0.50 to 0.99, plus 1.00 to 1.24, plus 1.25 to 1.99. The percent calculations have been extrapolated to the 2007 population estimate for the total population of the state and for children aged 0-19.

Narrative:

Almost 40 percent of Illinois' children 0 to 19 years of age are living at or below 200 percent of poverty.

F. Other Program Activities

Please refer to "Agency Capacity" for a complete description of Illinois' Title V program.

G. Technical Assistance

See Form 15 for this information.

V. Budget Narrative

A. Expenditures

Form 3. The Department and its partners expended a total of \$135.2 million in Maternal and Child Health Partnership funds and \$255.7 million in other federal funds, for a total expenditure of \$390.7 million during FFY'05 to operate the state's Maternal and Child Health program. The Maternal and Child Health Partnership includes the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds and program income.

The differences in the amount of state funds budgeted and expended resulted from minor changes in the budget items or amounts used to meet the match and maintenance of effort requirement. The amount of local funds (the amount used as match for Abstinence-Only Education) changed as the amount of the federal Abstinence-Only Education grant award changed. The amount of program income (from the Family Planning program) exceeded the estimated amount budgeted for FFY'05 by about 5.6 percent. Some of the apparent differences in the amounts budgeted and expended result from budgeting on the state fiscal year and reporting on the federal fiscal year. Overall expenditures of partnership funds were within two percent of the budgeted amount.

DSCC expended \$19.2 million for CSHCN from all sources in FFY'05, an aggregate increase in spending of \$0.4 million over FFY'04. Even though there was a \$0.2 million decrease in federal Block Grant funds for CSHCN in FFY'05, DSCC was able to increase the total funds expended on CSHCN by utilizing an additional \$0.4 million of State and local resources and \$0.2 million of other federal grants. Since FFY'02, DSCC has seen a steady decline in federal MCH Block Grant funds through a reduction in Illinois' allocation of MCH funds, in addition to the state's reduction in the funds for CSHCN from 32.1 percent to 30 percent of Illinois' allocation. In order to offset the decline in federal and State funds, DSCC worked with the Illinois Department of Healthcare and Family Services to identify the Medicaid-eligible children in the CSHCN program receiving care coordination services. DSCC was able to sustain the level of services for CSHCN in large part through this collaborative effort to generate additional revenue through Medicaid Administrative Claiming.

//2008/ The Department and its partners expended a total of \$144.4 million in Maternal and Child Health Partnership funds and \$254.8 million in other federal funds, for a total expenditure of \$399.2 million during FFY'06 to operate the state's Maternal and Child Health program. The Maternal and Child Health Partnership includes the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds and program income. //2008//

//2008/ The differences in the amount of state funds budgeted and expended resulted from minor changes in the budget items or amounts used to meet the match and maintenance of effort requirement. The amount of local funds (the amount used as match for Abstinence-Only Education) changed as the amount of the federal Abstinence-Only Education grant award changed. The amount of program income (from the Family Planning program) exceeded the estimated amount budgeted for FFY'06 by about 50 percent. Some of the apparent differences in the amounts budgeted and expended result from budgeting on the state fiscal year and reporting on the federal fiscal year. Overall expenditures of partnership funds were within two percent of the budgeted amount. //2008//

//2008/ DSCC expended \$19.9 million for CSHCN from all sources in FFY'06, an aggregate increase in spending of \$0.7 million over FFY'05. The increase was the result of a \$0.3 million decrease in federal MCH Services Block Grant funds in FFY'06, and an increase in the funds expended from state and local resources of \$1 million. Since FFY'02, DSCC has seen a steady decline in federal MCH Services Block Grant funds, due to reductions in Illinois' portion of MCH

funds and the state's decrease in funds allocated to CSHCN from 32.1 percent to 30 percent. In order to offset the decline in federal and state funds, DSCC worked with the Illinois Department of Healthcare and Family Services to identify the Medicaid-eligible children in the CSHCN program receiving care coordination services. DSCC was able to sustain the level of services for CSHCN in large part through this collaborative effort to generate additional resources of \$1.3 million through Medicaid Administrative Claiming. //2008//

/2009/ The Department and its partners expended a total of \$282.6 million in Maternal and Child Health Partnership funds and \$324.1 million in other federal funds, for a total expenditure of \$606.7 million during FFY'07 to operate the state's Maternal and Child Health program. The FFY'07 expenditures were substantially greater than those reported in FFY'06 (\$207.6 million) due to the decision to consider all of the division's activities as part of the Maternal and Child Health Partnership. In addition to the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds, and program income, the Maternal and Child Health Partnership includes funds expended for youth services, delinquency prevention, domestic violence, Early Intervention and substance abuse prevention. //2009//

/2010/ The Department and its partners expended a total of \$278 million in Maternal and Child Health Partnership funds and \$322 million in other federal funds, for a total expenditure of \$600 million during FFY'08 to operate the state's Maternal and Child Health program. In addition to the Maternal and Child Health Services Block Grant, State funds used for match and maintenance of effort, other state funds, local funds, and program income, the Maternal and Child Health Partnership includes funds expended for youth services, delinquency prevention, domestic violence, Early Intervention and substance abuse prevention. //2010//

/2009/ DSCC expended \$18.9 million for CSHCN from all sources in FFY'07, an aggregate decrease in spending of \$1.0 million over FFY'06. The decrease was the result of a \$1.0 million decrease in funds expended from state and local resources from FFY'06. DSCC generated \$1.4 million through Medicaid Administrative Claiming. //2009//

/2010/ DSCC expended \$19.9 million for CSHCN from all sources in FFY'08. DSCC generated in excess of \$1million through Medicaid Administrative Claiming.//2010//

Form 4. The State of Illinois expended \$912,600 less for pregnant women than the amount budgeted. This was largely due to a shift in the population served through the Chicago Department of Public Health "Mini MCH Block Grant" toward children and adolescents. As a result, less of the total expenditure for the "mini-block" was allocated for services to pregnant women than the amount budgeted. Further, IDHS spent less on operations and the Cornerstone system than budgeted. Similarly, the amount expended for infants was nearly \$1.3 million less than the amount budgeted. In addition to the shift in the population served by the "mini block," IDHS expended less than the budgeted amount for Healthy Families Illinois and for the Cornerstone management information system during the reporting period. The State of Illinois expended \$441,500 more on children and adolescents than the amount budgeted. This was the result of a shift in the population served by the Chicago Department of Public Health's "mini-block" grant toward adolescents and by offsetting increases and decreases in spending in several program areas. These differences are largely due to budgeting on the state fiscal year, reporting on the federal fiscal year and the timing of payments during state fiscal years. The IDHS expended \$592,600 more for services to other adults than the amount budgeted. This was the result of expending more MCH Block Grant funds for Family Planning services than originally budgeted.

The IDHS is required by Circular A-87 to have a Public Assistance Cost Allocation Plan (PACAP). The U.S. DHHS Division of Cost Allocation has requested IDHS to have a Departmental Indirect Cost Allocation Plan for indirect costs to identify dollars that then become a part of the Public

Assistance Cost Allocation Plan each quarter in claiming federal reimbursement. IDHS does not use indirect rates for its programs. It is considered full costing on a quarterly basis. Amounts budgeted for indirect costs are converted to direct costs through the PACAP. The costs identified as administration reflect audit costs and PACAP costs in excess of actual personal services expenditures.

In FFY'05, DSCC spent in aggregate two percent more on services for CSHCN than in FFY'04. DSCC expended \$19.2 million from all sources in FFY'05, an increase of \$0.4 million over FFY'04. Even though there was a \$0.2 million decrease in the amount of federal MCH Block Grant funds in FFY'04, DSCC was able to increase the total funds expended on CSHCN by utilizing an additional \$0.4 million of State and local resources and \$0.2 million from other federal grants.

/2008/ The State of Illinois expended \$2.4 million less for pregnant women than the amount budgeted. This was largely due to budgeting on the state fiscal year and reporting on the federal fiscal year. Further, IDHS spent less on operations and the Cornerstone system than budgeted. The amount expended for infants was \$5.5 million more than the amount budgeted due largely to an expansion of the Targeted Intensive Prenatal Case management program. The State of Illinois expended \$186,485 more on children and adolescents than the amount budgeted. Again, this was primarily an artifact of state and federal fiscal year reporting. The IDHS expended \$3.4 million more for services to other adults than the amount budgeted. This was the result of program income generated through the Title X Family Planning program. //2008//

/2008/ The IDHS is required by Circular A-87 to have a Public Assistance Cost Allocation Plan (PACAP). The U.S. DHHS Division of Cost Allocation has requested IDHS to have a Departmental Indirect Cost Allocation Plan for indirect costs to identify dollars that then become a part of the PACAP each quarter in claiming federal reimbursement. IDHS does not use indirect rates for its programs. It is considered full costing on a quarterly basis. Amounts budgeted for indirect costs are converted to direct costs through the PACAP. The costs identified as administration reflect audit costs and PACAP costs in excess of actual personal services expenditures. //2008//

/2009/ The State of Illinois expended approximately the amount budgeted for pregnant women. The amount expended for infants was approximately a million more than the amount budgeted due largely to continued expansion of targeted case management program activities. The State of Illinois expended substantially more on children and adolescents than the amount budgeted due principally to a cost of living increase awarded to youth service providers. The IDHS expended \$2.4 million more for services to other adults than the amount budgeted. This was the result of program income generated through the Title X Family Planning program. //2009//

/2010/ The State of Illinois expended in FFY'08 slightly more than the amount budgeted for pregnant women. The amount expended for infants was approximately three million more than the amount budgeted due largely to continued expansion of targeted case management program activities. The State of Illinois expended substantially more on children and adolescents than the amount budgeted due principally to a cost of living increase awarded to youth service providers.//2010//

/2008/ In FFY'06, DSCC spent in aggregate approximately four percent more on services for CSHCN than in FFY'05. DSCC expended \$19.9 million from all sources in FFY'06, an increase of \$0.7 million over FFY'05. Even though there was \$0.3 million decrease in the federal MCH Services Block Grant funds allocated to DSCC in FFY'06, the total funds expended on CSHCN were increased by approximately \$0.7 million, because an additional \$1.0 million was spent from state and local resources. //2008//

/2009/ In FFY'07 DSCC spent in aggregate approximately four percent less on services for CSHCN than in FFY'06. DSCC expended \$18.9 million from all sources in FFY'07, a decrease of \$1.0 million than in FFY'06. Even though the federal MCH Services Block Grant funds allocated

to DSCC in FFY'07 remained the same, the total funds expended on CSHCN decreased by approximately \$1.0 million, because \$1.0 million less was spent from state and local resources.
//2009//

***/2010/ In FFY'08 DSCC spent in aggregate approximately six percent more on services for CSHCN than in FFY'07. DSCC expended \$19.9 million from all sources in FFY'08, an increase of \$1 million more than in FFY'07. Even though the federal MCH Services Block Grant funds allocated to DSCC in FFY'08 remained the same, the total funds expended on CSHCN increased by approximately \$1 million which was expended from local resources.
//2010//***

Form 5. The decrease in the amount budgeted for infrastructure building resulted from the conversion of budgeted indirect costs to direct costs through the PACAP process described earlier, as well as minor changes in the items included in the budget and expenditure reports.

In FFY'05, DSCC expended \$0.3 million more on direct health care services and an additional \$0.2 million for enabling services in FFY'05. Conversely, DSCC spend \$0.2 million less for infrastructure building services in FFY'05. This shift of funds from infrastructure building to enabling services was largely due to a shift in spending for services such as transportation, community outreach and other family support services.

/2008/ The decrease in the amount budgeted for infrastructure building resulted from the conversion of budgeted indirect costs to direct costs through the PACAP process described earlier, as well as minor changes in the items included in the budget and expenditure reports.
//2008//

/2008/ IDHS expended more than a budgeted during FFY'06 in direct health care and enabling services, due to increased costs associated with delivering services to teens and young families; the increases were \$3.7 million and \$2.7 million, respectively. //2008//

/2009/ In FFY'07, IDHS expended \$9 million more on infrastructure services than budgeted. The increase was an accounting issue in that all of the division's youth services programs were considered as MCH programming effort but were not accounted for in the original FFY'07 budget application. The expenditures for youth services programming is reflected in the FFY'09 application.//2009//

/2010/ In FFY'08, IDHS expended \$10.5 million more on infrastructure services than budgeted. As in FFY'07, the increase represents an accounting issue in that all of the division's youth services programs were considered as MCH programming but were not accounted for in the original FFY'08 budget application. The expenditures for youth services are budgeted in FFY'09.//2010//

/2008/ In FFY'06, DSCC expended \$6.9 million on direct health care services and \$6 million on infrastructure building services, which was approximately the same amount expended in both types of services in FFY'05. In FFY'06, DSCC augmented the amount spent on enabling services by \$0.7 million from \$6.2 million in FFY'05 to \$6.9 million. The increase in funds spent for enabling services is largely due to a shift in the type of services needed such as transportation, community outreach, and other family support services. //2008//

/2009/ In FFY'07, DSCC expended \$6.1 million on direct health care services and \$6.3 million on infrastructure building services, which was \$0.8 million less in direct health care services but \$0.3 million more in infrastructure building services than in FFY'06. DSCC spent \$6.4 million on enabling services, which was \$0.5 million less than spent in FFY'06. //2009//

/2010/ In FFY'08 DSCC expended \$5.8 million on direct health care services which was \$0.3 million less than FFY'07. DSCC spent \$6.8 million on infrastructure building services and

\$7.4 million on enabling services in FFY'08 which was an increase of \$0.5 million for infrastructure building services and an increase of \$1.0 million in enabling services from FFY'07. //2010//

B. Budget

The Department has broadened the scope of programming and resources included in the Maternal and Child Health Services Block Grant to include all of the effort directed toward the health of children and women of child-bearing age in the entire Division of Community Health and Prevention. As a result, Forms 3, 4, and 5 indicate substantial increases in the budget. This represents the full range of activities under the control of the Director of Community Health and Prevention, who is now Illinois' Title V Director.

IDHS, DSCC, and IDPH use state General Revenue Funds, Tobacco Settlement funds, Title IV (DCFS) funds, Title X (Family Planning) funds, Title XX (Social Services Block Grant) funds, MCH Set-aside funds, Healthy Start Initiative funds, Closing the Gap funds, funds from the Substance Abuse and Mental Health Services Administration, USDA funds for Special Supplemental Nutrition Program for Women, Infants and Children (WIC), U.S. Department of Education funds for Part C of the Individuals with Disabilities Education Act and GEAR UP, U.S. Department of Justice funds for juvenile justice and domestic violence and funds from private foundations in addition to Title V Block Grant funds to achieve the objectives described in this application.

/2008/ Form 3. The federal Abstinence Education Only grant was discontinued for FFY'08. Local MCH funds used in past years as match for this grant were not budgeted for FFY'08. //2008//

Form 4. IDHS has budgeted \$716,400 less for pregnant women in FFY'07 than FFY'06. This is largely due to reallocating the budget for the All Our Kids Assurance Networks from the budget for pregnant women to the budget for infants (a more appropriate classification). IDHS has also budgeted \$4.8 million less for infants in FFY'07. This is largely the result of changing the amount and allocation of state Early Intervention program funds for FFY'07. In FFY'06, \$13 million of state Early Intervention funds were allocated as enabling services for infants. In FFY'07, all \$61 million of state Early Intervention funds have been included in the Partnership; they were allocated across services for infants and older children on Form 4, based on the age distribution of the program's caseload. The reallocation reduced to \$8 million the amount of these funds allocated to services for infants.

/2008/ IDHS budgeted approximately \$13 million more for children from age one to 22 years in anticipation of a cost of living increase for providers of services to adolescents. //2008//

/2009/ IDHS budgeted approximately \$8 million more for children from age one to 22 years in anticipation of a cost of living increase for providers of services to adolescents.//2009//

/2008/ Form 5. Budgeted increases in FFY'08 for direct health care and enabling services are due to anticipated increases in the cost of providing services to adolescents among IDHS service providers. //2008//

/2009/ Budgeted increases in FFY'09 for enabling service are due to anticipated increases in the cost of providing services to adolescents among IDHS service providers. The increase in infrastructure reflects the department's plans to modernize its major maternal and child health information system, Cornerstone. //2009//

/2010/ Budgeted increases in FFY'10 for infrastructure accounts for projected expenditures for all of the division's youth services programs.//2010//

Match and Maintenance of Effort. The amount of state support for the MCH program was \$27,569,600 in FFY'09. The required match for FFY'07 is \$16,575,000. The State of Illinois has

exceeded these requirements by providing \$30,584,400 in State funds.

Programs of Projects. IDPH had five "programs of projects" in 1981. Maternal and Infant (M&I) and Children and Youth (C&Y) projects were consolidated with the childhood lead project at the Chicago Department of Health and continue as a consolidated MCH project (the "MCH Mini Block Grant"). The Winnebago Family Planning Project and the Lake County Family Planning Demonstration Project continue as part of IDHS' comprehensive Family Planning program. The Intensive Infant Care Project at St. Francis Medical Center in Peoria continues to operate as a part of the Illinois regionalized perinatal care program. The amount of funding awarded to each project is as follows: Winnebago Family Planning, \$420,500; St Francis Perinatal Center, \$328,800; Chicago Department of Public Health (M&I, C&Y) \$5,017,400; Lake County Family Planning Demonstration, \$398,800 and the Dental Projects, \$398,000.

Section 501 purposes. Sections 501(a)(1)(A) through (D) of the Social Security Act as amended by OBRA'89 describe the basic purposes of the MCH Block Grant. Illinois plans to use MCH Block Grant funds to achieve these purposes through its system development activities, as well as by providing grants for preventive and primary care services to agencies statewide. The purposes outlined in Sections 501(a)(1)(A) and (B) are achieved by the grants IDHS awards for family case management and adolescent health promotion and the grants that IDPH awards for perinatal care. The purpose outlined in Section 501(a)(1)(C) is achieved by DSCC, in part with MCH Block Grant funds. The purpose outlined in Section 501(a)(1)(D) is the principle responsibility of DSCC. The proportion of funds used for Sections 501(a)(1)(A) and (B) is 70 percent, and for Sections 501(a)(1)(C) and (D) is 30 percent.

Allocation of Resources. IDHS receives the MCH Block Grant and administers primary care programs. IDHS transfers 30 percent of its block grant funds to DSCC for the CSHCN program. IDHS gives highest priority to those areas in Illinois that have high concentrations of low-income families (an area where 20 percent of the families, or at least 1,000 individuals, have an income at or below the federal poverty level), that are medically under-served areas, or are areas of high infant mortality and teenage pregnancy. Priority is also given to areas with high rates of poverty that have a demonstrated need for services. Program grants are awarded to local political jurisdictions or private, non-profit agencies. Applications are reviewed by a committee and recommendations for funding are made to the Secretary of the Illinois Department of Human Services. Continuation applications receive priority in order to maintain continuity of services.

Section 508 Purposes. IDHS has continued to direct funds to mandated Title V activities. Funds allocated to the State under this Title will only be used in a manner that is consistent with Section 508 to carry out the purpose of Title V or to continue activities previously conducted under the Consolidated Health Programs. IDPH continues to fund statewide projects addressing lead poisoning, genetic diseases and the SIDS program, while IDHS continues to fund programs related to adolescent pregnancy.

Fee Scale. IDHS has not established a fee scale for use by its MCH program grantees and has no plans to do so. Each project funded through the MCH program may elect to charge eligible recipients for certain services provided by the project. However, a flexible sliding fee scale must be used when a project intends to charge for services and no fees are charged to low-income clients. The fee scale must be included for approval in the project application prior to any fees being charged. Further, all projects are required to have agreements with the Medicaid program for reimbursement of covered services for project patients who are Title XIX, Title XXI or All Kids recipients. Steps must also be taken to obtain reimbursement from non-profit, semi-private and private medical insurance programs when those programs cover services rendered by the projects. Finally, outpatient services must be provided at rates established by the Illinois Department of Healthcare and Family Services for the Medicaid program. These provisions are made to ensure that mothers and children from low-income families are not charged for services.

CSHCN. Through effective benefit management strategies, DSCC was able to offset project

budget deficits, as they would potentially impact available funds for direct services for CSHCN. These strategies include increased staff training on benefit plans, taking advantage of contract discounts between medical care providers and insurance carriers, utilization of negotiated provider write-offs, and the use of dispute resolution techniques. DSCC has been able to redirect funds to assist families through enabling services in accessing health care by providing financial assistance for transportation and establishing a family incentive program to maximize health benefits by reimbursing families for insurance co-payments on medical visits and medications.

/2008/ Through effective benefit management strategies, DSCC has been able to offset budget deficits, as the reductions have significantly impacted the available funds for direct services to CSHCN. These strategies include increased staff training on insurance benefit plans, taking advantage of contract discounts between medical providers and private insurance carriers, utilization of negotiated provider write-offs, and increased benefit coordination efforts with the Medicaid program. In FFY'06, DSCC was able to redirect an additional \$0.7 million of funds to assist families through enabling services in accessing health care by providing financial assistance to cover transportation costs to access medical care and establishing a family incentive program to maximize health benefits by reimbursing families their insurance co-payments on medical visits and medications. //2008//

/2009/ In FFY'07, DSCC spent \$6.4 million on enabling services which includes assisting families to access health care by providing financial assistance to cover transportation costs and continued the family incentive program to maximize health benefits by reimbursing families their insurance copayments on medical visits and medications. //2009//

/2010/ In FFY'08, DSCC spent \$7.4 million on enabling services which was \$1.0 million more than in FFY'07. These additional funds for enabling services assists families in accessing health care by providing financial assistance to assist with transportation costs and to reimburse families for their insurance co-payments on medical visits and medications as an incentive to maximize health benefits. In addition, DSCC spent \$6.8 million in FFY'08 on infrastructure building services through enhanced care coordination training, policy development, and implementation of needs assessment strategies and quality assurance teams. The amount DSCC spent on infrastructure services in FFY'08 was \$0.5 million more than FFY'07. DSCC spent \$5.8 million on direct services for children in FFY'08 which was \$0.3 million less than in FFY'07 as strategies to educate families to use other primary payers has shifted direct service expenditures to private insurance and public payers.//2010//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.